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THE ROLE OF ELECTROCARDIOGRAPHY IN CLINICAL MEDICINE.[1]

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I AM conscious of the compliment paid me in being asked to give this talk. I realize that there are others who, were it not for the exigencies of the times, might have been accorded this distinction. Nevertheless I find satisfaction in stating the case for electrocardiography, since I venture to say that no branch in the realm of medicine is actually less pretentious for its stature yet more inveighed against and misunderstood.

Electrocardiography has been the object of research by the world's best physicists and physiologists for nearly a century. It depends for its interpretation on an intimate knowledge of the minute anatomy and physiology of the heart, on a broad clinical concept and on common sense. It is indispensable in the prognosis, diagnosis and treatment of disease. It is accordingly to be regretted that this field of medical science is frequently the object of belittlement and misconception even by those who should know better. If at times disappointment is felt in the ability of the electrocardiogram to clarify a cardiological problem, the blame attaches almost invariably to somebody or other who is unaware of its limitations.

So many excellent books appear on electrocardiography that one is beset with a sense of frustration in an attempt at an original contribution. It remains for one to state his honest convictions and delegate to himself the role of being helpful along lines that hitherto he has wished for himself. The title of this paper is rather one for a book, and as new thoughts present themselves I have found it difficult to compress the relevant matter into a reasonable space. It is for this reason that I have especially selected for discussion those phases of the subject wherein controversy and errors of nomenclature prevail. For an approach it has been found necessary to review, briefly, the history of electrocardiography and the physical and physiological principles underlying its interpretation.

[1] Read at a meeting of the Section of Medicine of the New South Wales Branch of the British Medical Association on September 14, 1944.

HISTORY.

It is said that the history of a science is the science itself, and though the centenary of electrocardiography is at hand, strange misapprehension prevails as to its inception.

One hundred and fifty years ago John Hunter studied animal electricity by using the electric ray or torpedo fish. In 1856 Kölliker and Müller demonstrated an action current in the frog's heart by laying it in contact with a nerve-muscle preparation. Little use could be made of this fact until in 1878 two English physiologists, Sanderson and Page, recorded, for the first time, the minute heart current by means of the capillary electrometer. In 1887 Waller showed, without opening the chests of laboratory animals, that the delicate heart currents could be led off from the arms and legs, and in 1889 recorded the first human electrocardiogram. The photographic recording of the mercury column was a tedious procedure, and the real start in clinical electrocardiography was made when, in 1903, Einthoven made use of the string galvanometer. At the commencement of the second decade of the present century, Lewis and Mackenzie in London, and Wenckebach in Vienna, brought the electrocardiogram into clinical prominence in the elucidation of the arrhythmias. Its main use persisted in this direction until the year 1919, when its value was enhanced by Herrick in the evaluation of the coronary circulation.

THEORY AND PRINCIPLES OF INTERPRETATION.

From the foregoing it is apparent that electrocardiography is founded on the physiological fact that the contraction of a muscle is accompanied by a minute electrical current, and that the interpretation of the waves of the electrocardiogram induced by these action currents of the heart is based on the effects noted when a simple strip of muscle is connected at each end with a galvanometer.

Whereas hitherto the interpretation of electrocardiography has been empirical and speculative, modern standards compel an understanding of the laws governing it. The mathematical formula of the triangle convened by Einthoven to reveal the two-dimensional electrical axis of the heart has either been confused with the theory underlying the science of electrocardiography or unduly availed of to determine the anatomical axis and hypertrophy of a particular chamber of the heart.

For a proper appraisement and appreciation of the deviations from the isoelectric line, as an example, it is essential to remember that the heart normally is surrounded by an electric field only during its phases of activation (depolarization), and restitution (repolarization) of its cycle; that is to say, no action currents are developed during the completely activated or resting phase, except where injury currents supervene. To understand the limitations of the electrocardiogram, it is further necessary to realize that the deflections produced by the potential differences between any two electrodes merely represent the favoured area between those electrodes and not the whole heart muscle. With an understanding of the origin of these waves and deflections of the electrocardiogram, their interpretation is based on experience.

Physiological Properties of the Heart.

From a knowledge of the reasons for the deflections in the electrocardiogram and with the ability to integrate them in terms of the normal and morbid anatomy of the heart, there arises the further necessity for an appreciation of the five physiological properties of the heart.

It is not sufficiently recognized that three only of these properties—rhythmicity, conductivity and irritability—are revealed electrocardiographically—that is to say, where the beat originates, how it spreads, and its power to respond to and conduct stimuli. No information can be obtained as to the tone or power of contraction of the heart, or (except inferentially) as to its size.

Arrhythmia.

Though the ability to identify an arrhythmia is in direct ratio to the clinician's experience, it is frequently advisable to seek confirmation electrocardiographically for the following reasons: (i) in view of unpredictability, (ii) for its psychological value, (iii) to assist prognosis, (iv) as a guide to digitalis and quinidine therapy, and (v) to save face.

With regard to "unpredictability", the following tabulation sets out the relevant considerations.

A. "Regular" arrhythmias.

- (*a*) Normal heart rate with disturbance of rhythmic conduction, as in auricular, nodal or ventricular block; nodal rhythm; tachycardias with periodic conduction; interpolated premature systoles.
- (*b*) Rapid heart rate—for example, the tachycardias.
- (*c*) Slow heart rate—for example, partial, intermittent, or complete heart block; premature beats not heard at the apex or felt at the wrist (Figure I); auricular flutter with "one in four" conduction.

B. Irregular arrhythmias with sinus, auricular, auriculoventricular nodal or ventricular mechanism (Figure II).

C. Variation in quality or arrest of beats—for example, *pulsus bigeminus, pulsus alternans, pulsus paradoxus,* asystole or inadequacy of the circulation.

With regard to the psychological value of electrocardiography, the risk of a cardiac-fixation neurosis is removed when reassurance is given with a voice of authority, without equivocation, and assisted by mechanical conviction.

The electrocardiogram is of prognostic importance, for example, to identify the arrhythmia, to discover whether the premature beats are of the same pattern, to learn the type of block *et cetera* (Figure III).

The electrocardiogram serves as a guide to digitalis and quinidine therapy (Figure IV). As an example, by the former treatment an auricular flutter may be changed to a rate of seventy beats per minute, and one is led into assuming that normal rhythm has eventuated. Any attempt to change abnormal to normal rhythm by quinidine treatment should be regularly controlled by electrocardiography.

The electrocardiogram may be used "to save face" (Figure V).

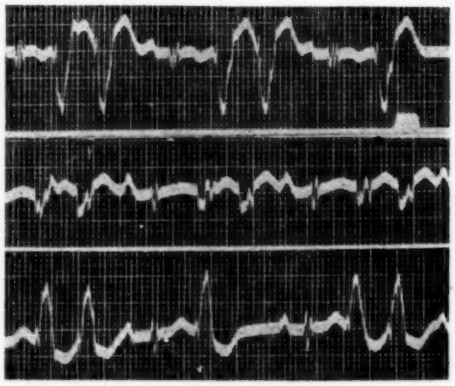


FIGURE I.

To illustrate a problem of evaluation of an arrhythmia without recourse to electrocardiography. This is a record of a patient suffering from advanced cardiac decompensation, inadequately treated with digitalis. The tracing shows premature beats occurring singly and in pairs. The first sound only of these extra beats was heard, and the sounds at the apex were irregular in force and rhythm. The radial pulse rate, however, amounted to 42 beats per minute, and the pulse was regular. Though the heart was grossly enlarged, the low voltage of the *QRS* complexes shows poor physiological function and renders the question of axis deviation inapplicable.

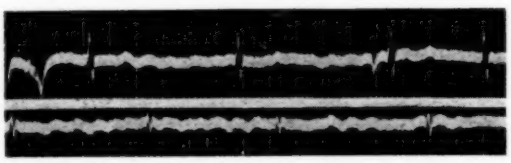


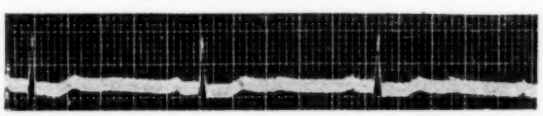
FIGURE II.

Auricular fibrillation in an army recruit who had no previous history of illness or symptoms, and who rode a bicycle fifteen miles each way to work every day.

Coronary Artery Disease.

In the field of coronary artery disease, in which electrocardiography has probably its major use, professional infelicity and discord are both excessively and unnecessarily rampant. The reasons are easy to follow. Clinical evaluation will continue to be hindered or unaided while the cardiographer is asked to function as a robot

Before atropine.



After atropine.

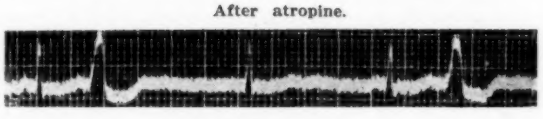


FIGURE III.

This was a patient who suffered from arrhythmia occurring more or less constantly for weeks, and sent for investigation by an astute and inquiring country doctor. On her arrival, her pulse was regular, and it seemed that she might have to return to the country without a solution of the problem. Atropine was given intravenously, and the result was the observation of ventricular premature systoles of one pattern.

interpreter rather than as an electrocardiologist. It may be conceded that if he is a sound cardiographer he is an efficient cardiologist and should be utilized as such to justify his existence and his fee. Needless to say, it will be an added advantage if he is an accomplished physician. If, however, after a clinical survey of the patient for the correlation of his records, the electrocardiographer volunteers an opinion over and above the interpretation asked for, he may be regarded as, or have a sense of, having exceeded his commitments, and so he may refrain from subscribing help he may have to offer. The referring colleague may have perfectly valid and just reasons for imposing bed rest for presumptive infarction, and he frequently is, though he need not be, surprised when he receives a "normal" electrocardiographic report. Such a negative finding in suspected early infarction should not be acted upon until serial electrocardiography has been carried out (Figure IX).

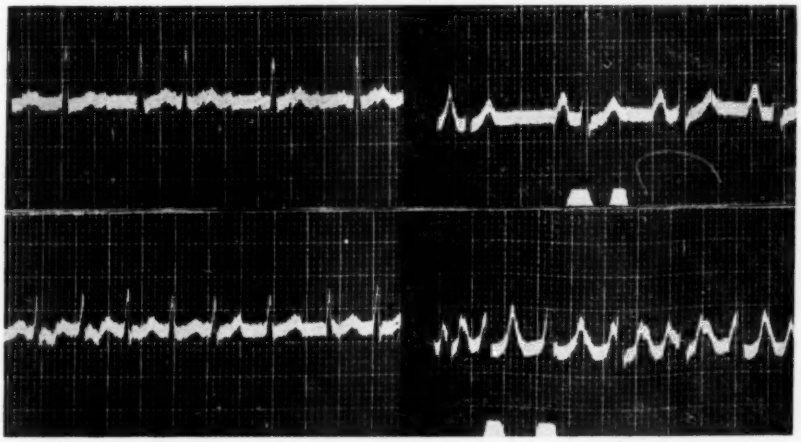


FIGURE IV.

To show the transitoriness, at times, of reversion to normal rhythm. Both tracings were taken at the one recording, the leads being repeated because of suspected interference. Fortuitously Lead II in A shows sinus rhythm, though as far as could be ascertained auricular fibrillation was constant. Once a paroxysmal feature had been established, an attempt at restoration of sinus rhythm by quinidine would be justified, especially as the patient was showing signs of decompensation.

The conflict generally centres around the terms "coronary sclerosis" and "coronary occlusion". It cannot be stated too definitely that the electrocardiographic diagnosis of uncomplicated coronary disease or sclerosis is impossible. The electrocardiogram will be altered only when coronary artery disease interferes materially with the nutrition of the heart muscle, so that ischæmia or infarction has resulted. No injury currents may be developed in the severest angina, or the restitution process may be so rapid that no electrocardiographic changes will be detected.

When we allow for the fact that coronary occlusion may not result in infarction, and further, that it is too frequently regarded as collateral to angina with or without cardiac shock, it would seem that the term "coronary occlusion", unless used in the proper clinical perspective, is ill-advised and impracticable and imposes a false expectancy on the electrocardiogram, since no parallelism

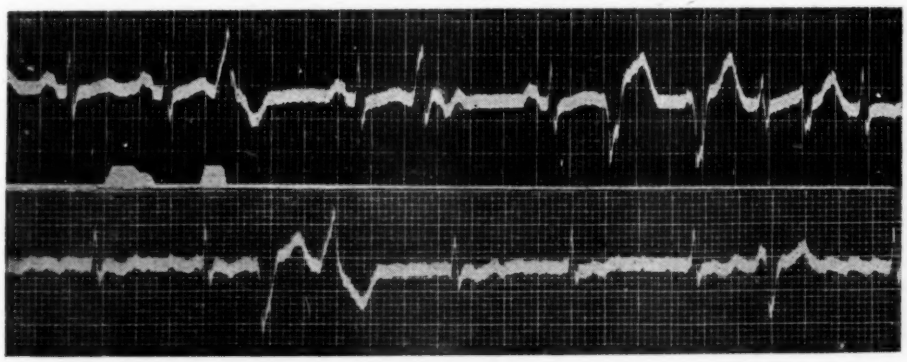


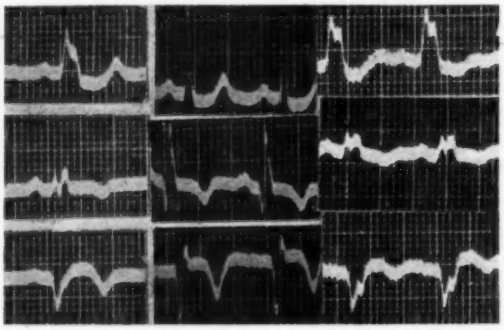
FIGURE V.

In explanation of the last sentence in the section on arrhythmia the following case is cited. J.D.H., a male patient, aged fifty-seven years, was referred on January 25, 1944, with the diagnosis of auricular fibrillation. The electrocardiogram (A), however, showed sinus rhythm with multiform ventricular premature beats. No digitalis had been given. His own doctor was informed that digitalis might not help and that the prognosis was unfavourable. As his condition did not improve, he consulted a colleague eight months later. The tracing taken then (B) reveals that in the interim the rhythm had changed to auricular fibrillation. It might be said that "face" was "saved" through my having a previous record as objective evidence.

exists between either the degree or the fact of closure and resultant cardiac abnormality and injury currents.

The Reason for the QRS Complex, the ST Segment and the T Waves.

For the proper interpretation of the prognostic and diagnostic implications in the evolution of the electrocardiogram in coronary artery disease, it is essential to have a working knowledge of the electrophysiological principles underlying the changes in the *QRS* complex, the *ST* segment and the *T* waves.



A B C

FIGURE VI.
To illustrate how the *QRS* complex may be reversible. Records A, B and C, taken at monthly intervals, are from a posterior wall infarction with septal involvement. In B the duration of the *QRS* complex has temporarily returned to normal, suggesting a background of ischæmia.

The QRS Complex.

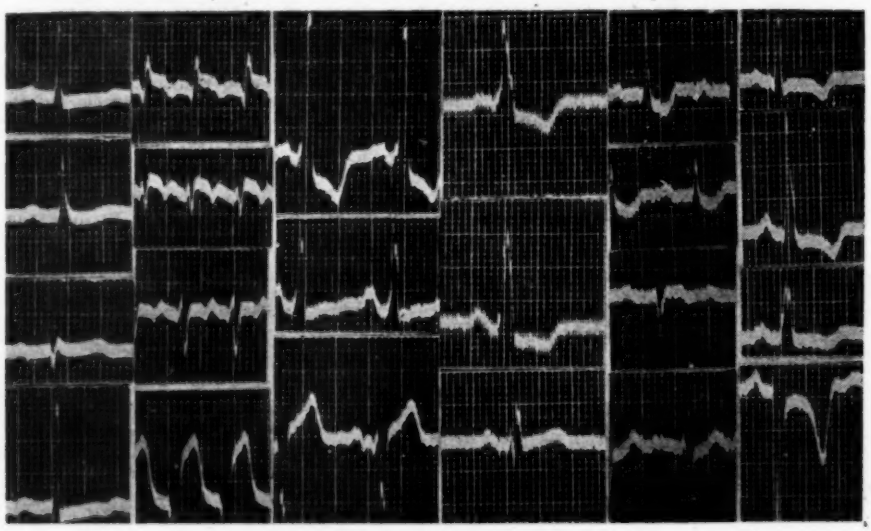
The *QRS* complex is affected when there is any inhibition of activation or any alteration in the pathway of the activation impulse, such as by ischæmia or by the scar of infarction respectively. In the latter instance the pattern is irreversible and will be altered only through any ultimate change in the position of the heart; that is, the coronary contour of the *QRS* complex may persist and give no information regarding the healing of the infarct. An instance of reversibility is shown in Figure VI.

The ST Segment.

Far too much misinterpretation prevails in, and too little attention is given to, that highly informative segment of the cycle, the *ST* segment. The *ST* segment embraces the phase when all parts of both ventricles are in the activated state, and theoretically should be isoelectric. Two main factors tend to prevent this: (i) the deactivation of the auricles continues into the *ST* segment; (ii) the start of the *T* wave or restitution process in the ventricles is slow, and the *ST* segment slopes up in such a way as to mask the beginning of the *T* wave, so that it is difficult to say where *ST* ends and where *T* begins.

Accurate designation is essential of the slope, level and curvature of the *ST* segment and the relation of these to the direction, size and contour of the *T* wave. A careful check of the standardization should be made for evidence of over-damping or under-damping, which invalidates the above-mentioned features.

The *ST* segment may develop its abnormalities (*a*) suddenly or (*b*) slowly, and it is convenient here to deal with the differential aspect, since bed rest can be so illogically applied. Sudden or recent changes in the level and deviation of the *ST* segment are, of course, of prime importance in the diagnosis of infarction. The coronary or *ST* stage may reach its maximum in from a few hours to a week and may remain for weeks or disappear in a few days. Other conditions with similar clinical implications embracing sudden *ST* changes, such as pericarditis, pulmonary embolus, and possibly acute abdominal emergencies with reflex vagal coronary constriction, will be diagnosed through an awareness of their possibility.



A B C D E F

FIGURE VII.
Showing the main differential features of the *ST* segment. A: The low *T* waves in the standard and chest leads are presumptive evidence of myocardial degeneration due to coronary sclerosis. B: The high take-off in Lead I and Lead II with *T* inversion indicates very recent anterior wall infarction. C and D: These tracings are from the one patient at an interval of eight months; C shows advanced left ventricular strain, and D shows intraventricular block (common type). Both show the depressed *ST* segment deviated in the same direction and curved in the opposite direction to *T* in Lead I. In D the *QRS* complex duration is increased and the axis deviation no longer exists. E: Showing effect of digitalis (see text); this patient had taken three "Digoxin" tablets per day for twenty-nine days. F: Showing chronic or irreversible coronary insufficiency without a background of hypertension. There was a suggestive history of infarction two years previously.

The principal conditions for differential diagnosis in slow or chronic developed *ST* changes are (*a*) advanced ventricular preponderance, (*b*) intraventricular block, (*c*) excess of digitalis, and (*d*) coronary insufficiency without a background of hypertension. In the first and second of these conditions, when the *T* wave is opposite to the main deflection, the *ST* segment is depressed, deviated in the same direction as the *T* wave and straight or curved in the opposite direction to it. In intraventricular block the *QRS* complex will be prolonged (Figure VII, C and D). In excess of digitalis, the *ST* segment of Leads I and II will first be depressed and the *T* wave progressively inverted. The *ST-T* complex ultimately forms one element, and its development can be visualized by pushing down its middle third with the end of the *T* and the top of the *R* waves fixed (Figure VII, E). In passing it is well to remember that digitalis excess, like syphilis in internal medicine, can mimic almost any feature in electrocardiography; further, it should be remembered that the property of conductivity is involved in digitalis action, since the changes produced by it are uninfluenced by atropine. In coronary insufficiency without a background of hypertension the tracings alter very little if at all over a series, and are stabilized in such a way that the *ST* segment is isoelectric and curved in the opposite direction to the *T* wave (Figure VII, F). The main difficulty occurs when recent infarction has to be excluded or when there are associated conditions. It is here that the value of a previous tracing for comparison arises, since otherwise the composite result must be considered in the light of the clinical features and regarded suspiciously pending serial electrocardiography.

The Coronary T Wave.

Apart from any considerations of abnormal *ST* features, changes in the *T* wave occur in the form of voltage or change in direction. In the former case, while diffuse myocardial damage may result in low voltage, no general rules can be laid down. Voltage should not be confused with amplitude.

In a percentage of cases of *T* wave inversion more mental reservation should be indulged in before this feature is accepted as unequivocal evidence of infarction old or recent. A most painstaking history embracing the personality and reliability of the patient may not assist, and a rest period should be enjoined pending serial electrocardiography. If after an interval from say three months onward the electrocardiographic appearances remain unaltered, the term chronic or irreversible coronary insufficiency may be instituted, and the patient may be permitted activity in keeping with his cardiac capacity.

What, on the other hand, is to be the clinician's attitude in the case of a presumably healed myocardial infarct, in which the *T* wave waxes and wanes at varying intervals sometimes from negative to positive? In addition there may be no deterioration of heart performance (Figure VIII). This situation invites the further question: "What are the electrophysiological principles involved?" The following explanation is offered. Experimental work suggests that *T* wave inversion is due to prolonged or depressed activity of a diseased focus of the heart muscle with repolarization lagging behind in this area. Around the healed scar the circulation varies from time to time, perhaps merely through altered tone of the cardiac nerves, local ischæmia results and injury currents are set up.

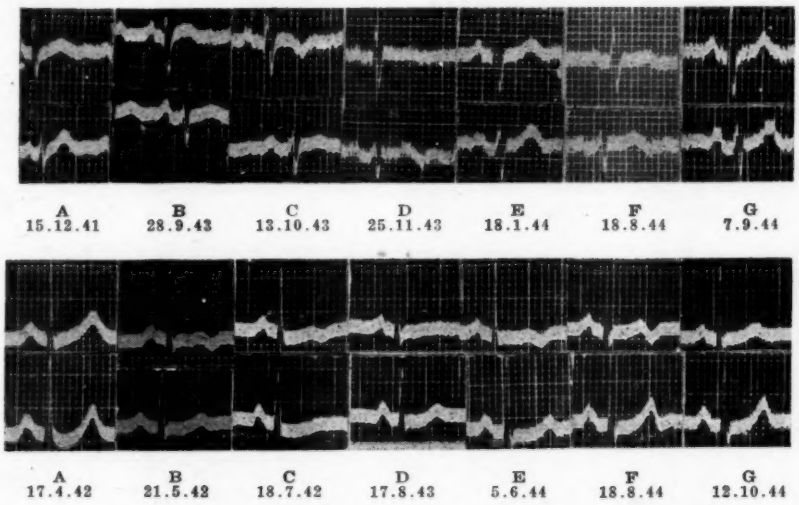


FIGURE VIII.

A series of records showing the waxing and waning *T* stages and their significance; the leads are I and II throughout. In X, record A was taken as a routine measure in a case of essential hypertension; B was taken ten days after an anginal episode, unrelieved by trinitrin. The difference in the *T* waves heralded a change in cardiac abnormality, which manifested itself more frankly in C, fourteen days later. D and E, taken six weeks and three months later respectively, suggest that the lesion responsible for the injury current was inconsiderable, since the *T* waves returned to normal so quickly. Record E is a replica of G, and occurs between D and F, which are replicas of each other. Y illustrates the value of serial cardiography from both the diagnostic and the prognostic aspect. Record A was taken fourteen days after a fairly characteristic episode of coronary occlusion. Other than slightly unusual *ST* segments the tracing is normal. B, taken about a month later, shows anterior wall infarction with inverted *TI* and lowered *TII* waves. Though the *T* wave in Lead II (D) became upright sixteen months later and has remained so, *TI* waxes and wanes in the absence of any clinical suggestion of a fresh occlusion. The patient of X series is hypertensive and has episodes of protracted angina unrelieved by trinitrin. The patient of Y series is hypotensive and has attacks of the nature of runs of premature systoles, especially on the eve of important social engagements, though at such times his colour may be disturbing. The underlying morbid condition in both cases is one of focal or subendocardial necrosis and not massive infarction, and the physiological state of acute or transitory coronary insufficiency may be induced, especially in Y, through altered tone of the cardiac nerves. Between attacks the exercise tolerance of each patient is fairly good, and care should be taken to avoid undue curtailment of such people's activities.

The practical outcome of these considerations is that the recurring features should not necessarily be labelled as either fresh infarction or chronic coronary insufficiency. A prognosis given with a pursing of lips and shrugging of shoulders and implemented with excessive bed rest will have the effect of developing what is the special problem to avoid—a cardiac fixation neurosis. Armed with these concepts, one may be permitted to suggest that the approach to the evaluation of *T* inversion should centre around (*a*) the nature of the vascular process, (*b*) the duration, (*c*) the underlying form of morbidity, (*d*) reversibility and (*e*) site. It would seem that unnecessary bed rest is the custom even in frank infarction, and it is my view that with the lapse of time far more latitude will be permitted, especially in the anterior wall type of cardiac infarction.

Axis Shift and Ventricular Preponderance.

Much looseness of interpretation and improper application surround the "axis shift" and "ventricular preponderance". The electrocardiographic features of hypertrophy of one or other ventricle may occur in conditions resulting from mechanical causes when the muscle is sound—such conditions as hypertension and mitral stenosis, or enlargement due to diffuse myocardial disease.

In any consideration of the electrical axis of the heart for the determination of preponderance, regard should always be had first of all to the prevailing anatomical axis in a vertical or transverse position of the heart, of which the two main causes are habitus and respiration. Secondly, the relationship between the electrical axis and hypertrophy is upset through any variation in the distribution or disease of the branches of the *AV* system (Figure VII, D). Thirdly, it may be said that in the case of a heart with poor physiological function the deflections of the *QRS* complex will be so reduced in size as to make the fact or otherwise of hypertrophy incomputable (Figure I). Lastly, no axis shift may be present in the severest cases of hypertension (Figure IX, A).

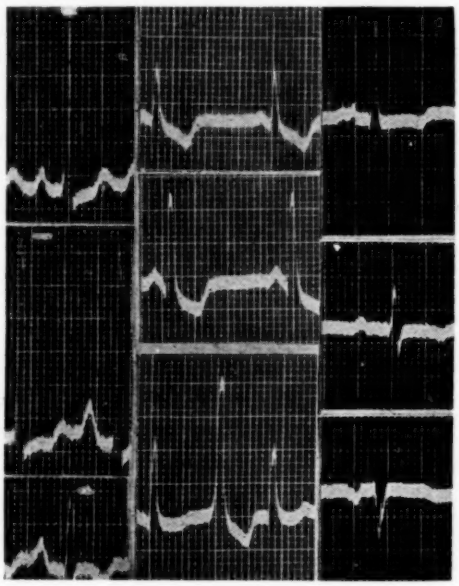
All charts and formulæ to correlate the *QRS* complex with definite degrees of hypertrophy of the heart by means of the electrical axis have their shortcomings, and this has led the committee of the New York Heart Association to set out as a rough clinical guide the criteria for evaluation of the deviations of the *QRS* complex.

Even with these criteria, seeming anomalies occur, and in cases associated with hypertension or other mechanical disability a better guide to heart performance is provided by inspection of the *ST* segment, though even here again the accuracy of the implications is not invariable by any means. This *ST* or restitution factor is conditioned by the manner of the activation process in the hypertrophied ventricle. Opinion is divided as to whether this *ST-T* factor in ventricular hypertrophy is due to the altered spread of conduction, or to the capillary bed's becoming relatively inadequate for the increased muscle mass, or to elongation of the bundle branches with delayed conduction.

The recent work by Wilson and Johnston with unipolar chest leads has done much to clarify and orientate the electrocardiogram of preponderance. These authors have shown, for example, that in hypertrophy of the left ventricle in a vertically placed heart the potential differences may be referred to the left leg, with large *R* waves in all the standard leads (Figure IX, A and B) and even at times right axis deviation.

The inverted *T* wave found at times in hypertrophy does not depend on the direction of the axis or on the degree of axis deviation or hypertrophy, and may be due to injury currents from ischæmia resulting from coronary sclerosis. The *T* wave is frequently inverted in those chest leads taken from the apex (Figure VII, F). Barnes and Whitton found a negative *T*I wave with or without a negative *T*II wave in 25% of cases of left ventricular hypertrophy, and a negative *T*II and *T*III wave in a similar percentage of cases of right ventricular hypertrophy. Rykert and Hepburn studied twenty cases of left ventricular hypertrophy in which the *T*I wave was inverted, and after a critical survey of the morbid histology in four of these cases failed to find evidence of myocardial degeneration or fibrosis, hypertrophy being the sole abnormal feature of the muscle.

Seemingly the point at issue arising out of this discussion would appear to be that the electrocardiographer, along with the radiographer, should guard against being subject to the charge of adding to the already unnecessary list of the "heart conscious".



A B C

Figure IX.

To show that the anatomical position of the heart determines the axis deviation, rather than hypertrophy of a particular chamber. Record A is that of a female patient, aged thirty-five years, with a systolic blood pressure of 270 millimetres of mercury and a diastolic pressure of 170, whose heart was vertically placed and who ultimately died of cerebral hæmorrhage. The *QRS* complexes were of high voltage and there was no axis deviation. Record B was that of a thin man with left ventricular hypertrophy from aortic incompetence. As the heart was vertically placed, no axis deviation was present. Record C is that of a man weighing 23 stone, who had normal blood pressure and early left ventricular failure. The heart in this instance was transversely placed, with resultant left axis deviation.

The Bizarre and Prolonged QRS Complex.

Misconception abounds in the diagnostic and prognostic significance of the bizarre and prolonged *QRS* complex. It occurs most frequently for interpretation in intraventricular block, aberrant conduction and premature systoles, and while the aspect of abnormal spread is a feature of all three conditions, it will be of assistance to view it as arising from (*a*) a refractory and (*b*) a non-refractory mechanism. In the first group the change in the *QRS* complex results from aberrant conduction due to a premature beat meeting a refractory mechanism. In the second group the prolonged *QRS* complex may result from alteration in the manner of spread of the impulse, as in idioventricular rhythm, or it may be due to a depressed ventricular pathway, and then it occurs characteristically in intraventricular block. Though intraventricular block may be used as a generic term for left and right bundle branch block, arborization block and *S* type block, the recent experimental work by Wilson and Johnston would appear to warrant an anatomical distinction. Be this as it may, the matter is really more academic than practical, and the prognosis should be determined in conjunction with the clinical evidence.

Discussion.

Clinical examination, embracing a carefully taken history, should not be subordinated to electrocardiographic study. The latter course may be the sole diagnostic means available. Frequently it is of use only in a supplementary or confirmatory way or to serve as a comparative record, and will become necessary to the clinician in inverse ratio to his knowledge of cardiology. Damage may exist in regions of the heart that cannot be revealed by electrocardiography. This especially applies to the lateral surfaces of the heart, where injury currents require to be gathered and transmitted through the lungs, which are poor conductors of electricity.

Further, it should be reaffirmed that evidence of damage or morbid process appears in the electrocardiogram only through the fact that (i) injury currents are set up, or (ii) the spread of the activation process is interfered with, or (iii) the origin of the heart beat is altered.

Two electrocardiograms with the same features may be associated with different clinical implications, and it is often unwise to assess the cardiac status from a single electrocardiogram, even when the clinician is handling his own clinical problem. The aspect of reversibility must ever be kept in mind, and serial electrocardiography instituted where doubt exists. A coronary contour atypical or otherwise may merely imply relative insufficiency of the myocardium arising out of a variety of causes, quite removed from any coronary structural defect. The degree of invalidism inflicted on people with heart conditions, alleged or otherwise, is frequently much to be deplored, and should be relegated to the limbo of unhappy forgotten things. In this respect the electrocardiogram should be used as a friend and not as a foe.

More dogmatism may be permissible with the expiry of time; in the interim it frequently begets a well-merited, if irreverent, sneer. Prognosis and diagnosis will be more assisted by an interpretative summary such as "within physiological limits", or "consistent with a clinical condition of", *et cetera*.

An unwarranted assumption may lead to the adoption of measures that will affect the fate of the patient. Features unduly regarded as vital or as pointing to a specific lesion or ætiology, are apt to bring distrust on the electrocardiogram. The truth lies in the fact that it is no less logical to impeach electrocardiography because of faulty interpretation than it is to indict surgery because of bad surgery, or to regard some clinical problem as an issue of insolubility rather than as one of clinical inadequacy.

Summary.

1. The history of electrocardiography and the physical and physiological principles underlying the interpretation of the electrocardiogram have been reviewed.

2. The limitations of electrocardiography in prognosis and diagnosis have been indicated.

3. A plea has been made for more accurate terminology.

4. The need for serial records has been stressed.

5. A proper concept of the *ST* segment is the *sine qua non* of efficient interpretation.

6. The illustrations, though limited, have been designed to validate the clinical progress and status of patients actually treated.

7. An explanation has been tendered to account for the so-called contradictions in axis deviation.

Acknowledgement.

My thanks are due to Miss M. Rolleston, librarian of the New South Wales Branch of the British Medical Association, for her assistance in securing the required literature.

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Reports of Cases.

THE Rh FACTOR: Rh SUBTYPE ISO-IMMUNIZATION IN AN "Rh-POSITIVE" MOTHER.[1]

By R. T. Simmons and G. A. Kelsall,

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The discovery of the Rh factor in human blood by Landsteiner and Wiener (1940) gave great impetus to blood investigations in many parts of the world. It was shown by Wiener and Peters (1940) that the Rh factor was responsible for the production of immune iso-agglutinins in man following repeated transfusions of blood from persons of the homologous A-O-B blood group. Iso-immunization in pregnancy due to the Rh antigen was demonstrated by Levine, Katzin and Burnham (1941) and by Wiener (1941). In both types of case the persons immunized were found to be "Rh-negative"—that is, their cells lacked the Rh factor.

It is now an accepted fact that in cases of *erythroblastosis fœtalis* (*hydrops fœtalis, icterus gravis neonatorum*, congenital anæmia of the newborn), now often termed hæmolytic anæmia of the newborn, the mother is "Rh-negative" in over 90% of the cases and is immunized by an "Rh-positive" fœtus. In the remainder of the cases it has been thought that iso-immunization is possibly due to an incompatibility in the A-B-O groups (Kelsall, 1944, and others) and that the fœtus is affected particularly in those cases in which the child would be a "non-secretor" of the A or B water-soluble group-specific substances, and that in still other cases agglutinins have been produced by an antigen other than the typical Rh factor.

Even in cases in which the mother is shown to be "Rh-negative" and the baby "Rh-positive", it is not always possible to demonstrate the presence of Rh antibodies in the mother's serum, and when their demonstration is possible, the Rh antibody titre is not always found to be correlated to the severity of the disease.

As work on the Rh factor has progressed, unusual cases of iso-immunization have been detected and reported. For instance, there is the rare case of Levine and Javert (1941), in which the mother was found to be "Rh-positive" and the infant "Rh-negative", while the mother's serum contained the so-called anti-Hr agglutinin. A somewhat similar agglutinin was reported by Race and Taylor (1943) in the serum of an "Rh-positive" mother. This agglutinin reacted with certain "Rh-positive" blood samples, including the husband's and that of the living children (one of whom was affected with hæmolytic disease). The agglutinin, which was named "St", reacted with all "Rh-negative" blood samples and with all heterozygous "Rh-positive" blood samples (Rhrh), but with only half of the homozygous "Rh-positive" blood samples (RhRh). Wiener (1944) reported a case of *icterus gravis* in which the mother, father and child were all "Rh-positive"; in this instance iso-immunization was due to a difference in Rh subtypes, the mother belonging to subtype Rh′, and the father and baby both belonging to subtype Rh_1Rh_2. The following quotation is from Wiener (1944), as two of the references given by him refer to personal communications:

> Rh-positive mothers of erythroblastotic babies, with blood giving reactions corresponding to the type Rh′ and with anti-Rh agglutinins in the serum, have also been encountered by Levine et al., Fisk and Ford, and more recently by Mollison.

There is also evidence that Rh antibodies have been demonstrated in the maternal circulation without any clinical symptoms of erythroblastosis being detected in the baby. Levine (1943) makes the following statement:

[1] Submitted for publication, September 7, 1944.

Very early in the course of these studies it was observed that two Rh– mothers with anti-Rh agglutinins had presumably normal babies. At least one of the infants was Rh+. Unfortunately, hæmological and clinical data are lacking to determine the presence or absence of a very mild form of anæmia.

Dockeray and Sachs (1944) report four cases in which they demonstrated antibodies without finding evidence of erythroblastosis. The evidence in three cases is incomplete or it appears to be open to some doubt; but one case demonstrates that strong anti-Rh agglutinins can be formed in the maternal circulation without evidence of any clinical manifestation in the baby. In this case the mother was "Rh-negative" and the baby "Rh-positive".

The purpose of this paper is to report a case which appears to be somewhat similar to that of Wiener's in demonstrating Rh subtype iso-immunization in an "Rh-positive" mother by an "Rh-positive" baby. While we were first of the opinion that the baby was perfectly normal, we now think, in view of later information, that the case might best be described as one of possible subclinical erythroblastosis.

The detection of this case was entirely accidental, in that iso-immunization was found when a search was being made for weak atypical agglutinins in certain maternity cases. This particular case was chosen at random as one of several normal controls to be included in our series. The mother had been shown to be "Rh-positive" when her blood was tested with only one human specimen of anti-Rh serum and the baby was found to be perfectly normal at birth. Samples of serum and cells were being obtained from mothers and babies at delivery and sent from Perth to Melbourne by air mail for subsequent tests, and as a result there was a delay of several days before tests were made. We were most surprised to find that the serum from this patient, Mrs. B., contained antibodies which agglutinated her infant's cells and those of known "Rh-positive" controls.

Clinical Record.

Mrs. B., aged thirty-four years, had had five pregnancies, as follows. In 1931 she gave birth to a daughter; delivery was normal, and the child was healthy at birth, with no signs of jaundice or anæmia at or soon after delivery. The child is alive and well. In 1934 another daughter was born; this child was normal, and is alive and well. In 1940 Mrs. B. had a miscarriage after three months' gestation. In 1942 a daughter was born; the baby had slight jaundice, which lasted for one month. This child died as the result of a motor-car accident in 1943. The child was otherwise healthy until her death. On June 3, 1944, Mrs. B. gave birth to a son. The pregnancy was uneventful, and delivery was normal at term. The baby weighed seven pounds two ounces at birth. Slight transient jaundice was noticed on the third day; it lasted for two days, but was so slight as almost to escape notice. It was taken by the attending doctor to be physiological jaundice, and as a result no investigations were requested. Both mother and child were apparently normal and were allowed to leave hospital on the thirteenth day, the mother being encouraged to feed the baby at the breast.

Blood specimens had been collected from both mother and child in Perth on June 3, 1944, at delivery, and on June 8 the presence of anti-Rh agglutinins was demonstrated in the mother's serum and later confirmed in a further sample of blood taken on June 16. A blood film from the baby, taken on June 16, was considered to be normal. Samples of cells were obtained from the mother, baby and two daughters on June 25 and tested for the Rh subtypes. On July 23 blood samples were obtained from the child's father and paternal grandfather and these also were tested for Rh subtypes. Blood samples and a specimen of milk were obtained from Mrs. B., but on subsequent tests no anti-Rh agglutinins were detected in the milk. Weak anti-Rh agglutinins were demonstrated in the sample of serum. A Kline test produced no reaction with serum from the mother, father and baby.

Baby B. was carefully examined on July 23, 1944, with the following results. The appearance was that of a normally developed child, but the baby was a little paler than normal. Neither the liver nor the spleen was palpable. A blood examination gave the following information: the hæmoglobin value was 11·3 grammes *per centum*, or 74% Sahli (15·3 grammes = 100%); the erythrocytes numbered 4,060,000 per cubic millimetre and the leucocytes 13,600 per cubic millimetre; of the leucocytes, 30% were neutrophile cells, 60% were lymphocytes, 4% were monocytes, 4% were eosinophile cells and 2% were basophile cells. Examination of a blood film revealed slight anisocytosis, a few polychromatic cells, no erythroblasts and no normoblasts; staining indicated slight hypochromia.

Mrs. B. has at no time been the recipient of a blood transfusion. There has been no jaundice in any member of the family, except as mentioned above.

An Introduction to Rh Subtypes.

As it was necessary, for the complete investigation of this case, to study the Rh subtypes of Mrs. B., her baby and other members of the family, it is felt that some mention should be made of the recent work carried out in America and England on the subtypes of the Rh factor. Wiener (1943) has shown that three varieties of anti-Rh agglutinins exist; these have been designated anti-Rh (standard), anti-Rh_1 and anti-Rh_2. These antisera agglutinate about 85%, 70% and 35% respectively of blood samples from white persons in New York City.

With these three antisera, five varieties of Rh agglutinogens have been demonstrated and named Rh_1, Rh_2, Rh, Rh′ and Rh″. These agglutinogens, in combination, give rise to eight Rh blood types including the "Rh-negative" type, and they are as follows: "Rh-negative", Rh_1, Rh_2, Rh_1Rh_2, Rh, Rh′, Rh″ and Rh′Rh″. In Table I (after Wiener, Sonn and Belkin, 1944) is shown the classification of Rh subtypes by means of the three anti-Rh sera.

TABLE II.

Mrs. B.'s Serum versus *50 Group O Cell Suspensions of Known Rh.*

Cells.	Number of Tests.	Result.
Rh-positive.	42	42 positive
Rh-positive	1[1]	1 negative.
Rh-negative.	7	7 negative.

[1] This person's cells were known to be Rh-positive, but of a comparatively rare subtype. Subsequent tests showed that this person's cells belonged to subtype Rh′; in Melbourne this subtype is present in about 1% of the population.

Wiener has postulated the existence of six allelic genes to explain the heredity of the Rh blood types, and has produced evidence (Wiener, 1944) which is in complete agreement with the theory. Independent work along similar lines has been reported by Race *et alii* (1943 and 1944), and is in agreement with the work done in America. The English classification of Rh subtypes differs slightly from the American classification, and in this paper the Rh subtypes referred to will correspond with those used by Wiener.

Materials and Methods.

Samples of cells and serum from mothers and infants at delivery were collected at Perth and sent to Melbourne by air mail, the time taken from "refrigerator to refrigerator" being approximately thirty-six hours. The cells were collected in Rous and Turner solution to which "Merthiolate" had been added to give a concentration of 1/100,000. On their arrival in Melbourne the cells were A-B-O grouped, MN typed and tested for the Rh factor, four human anti-Rh sera being used. It was noticed that Mrs. B.'s cells agglutinated with only two of the anti-Rh sera, while the infant's cells agglutinated with all four; this indicated a difference in Rh subtypes between mother and child. Both mother and child were found to belong to blood group OMN.

During the investigation, when we discovered atypical agglutinins in Mrs. B.'s serum, we were testing serum for the presence of weak atypical agglutinins by the technique of Wiener (1944); but we were using, instead of plasma, ten drops of serum *plus* one drop of cells and incubating the mixture in tubes in a water-bath at 37° C. for one or two hours. The sediment was examined macroscopically and microscopically for agglutination. It was then found that the agglutinins in Mrs. B.'s serum could also be demonstrated by the standard tube technique and also by the slide technique. In tubes and also on slides Mrs. B.'s serum agglutinated some cells to a "+" titre at 1/32 ("++++" being complete agglutination) and others to a "+" titre from 1/8 to 1/16. To prove that the agglutinin detected was anti-Rh, we then tested Mrs. B.'s serum against fifty group O cell suspensions of known Rh by the slide technique, incubating the material in moist chambers at 37° C. and observing agglutination at thirty and sixty minutes.

TABLE I.
Classification of the Rh Types.
(*After* Wiener.)

Reaction with Anti-Serum.			Type.	Reaction with Anti-Serum.			Type.
Rh_1	Rh_2	Rh		Rh_1	Rh_2	Rh	
+	+	+	Rh_1Rh_2	+	+	−	Rh′Rh″[1]
+	−	+	Rh_1	+	−	−	Rh′
−	+	+	Rh_2	−	+	−	Rh″
−	−	−	Rh-negative	−	−	+	Rh

[1] The rare subtype Rh′ Rh″ had not been encountered by Wiener early in 1944.

Results.

From the results shown in Table II it is seen that the agglutinin in Mrs. B.'s serum behaves exactly as do some other known human standard anti-Rh sera which we have previously used for testing purposes.

It was then decided to obtain more detailed information concerning the reactions which cells from Mrs. B. and baby B. would give with samples of thirteen human anti-Rh sera at our disposal. It was found that Mrs. B.'s cells reacted with only five of the thirteen sera, while baby B.'s cells reacted with all thirteen. With two samples of guinea-pig anti-Rh sera, Mrs. B.'s cells failed to react; this indicated that Mrs. B. belonged to one of the rare subtypes of Rh. The baby's cells reacted with the guinea-pig anti-Rh serum, as they also did with standard human anti-Rh sera which were known to give about 84% "Rh-positive" reactions. The reactions of infants' cells with guinea-pig anti-Rh serum are not significant, as all infants' cells yield positive reactions. This phenomenon was shown by Fisk and Ford (1942) and confirmed by Wiener and by others.

To prove that no error had been made in the taking or labelling of the original samples from Mrs. B. and baby B., we obtained further samples from both on the thirteenth day after delivery, and subsequent tests confirmed the results quoted above.

At this stage small samples of two anti-Rh sera for testing for the subtypes of Rh, kindly supplied by Dr. A. S. Wiener, became available to us, and with the cooperation of Dr. Rachel Jakobowicz we were able to determine the Rh subtypes of the family. The third serum (the standard anti-Rh) we already had, and the tests were carried out as recommended by Wiener. The results of these tests are shown in Table III.

From Table III it is seen that Mrs. B. belongs to a comparatively rare Rh subtype, Rh′, and that baby B. belongs to Rh subtype Rh_1. The case is therefore similar to that reported by Wiener, in which an Rh′ mother has been immunized by the baby owing to a difference in Rh subtypes.

Discussion.

This case is interesting, in that iso-immunization of yet another mother belonging to the comparatively rare Rh subtype Rh′ has been demonstrated. This case was found accidentally, as the mother and baby were chosen at random and their cells and serum included amongst the normal controls in a series of tests. One of us (G.K.), who collected the samples and saw the baby during the first two days, observed that the child was normal in every respect. Owing to absence in Melbourne, he did not see the baby again until the twenty-first day, and it was not until five days after delivery that the original blood samples were tested and the presence of anti-Rh agglutinins was detected in the mother's serum. When antibodies were found we sent to Perth for blood samples from the mother and films from the baby, and these were taken on the thirteenth day after delivery. The blood films, which were stained with Leishman's stain, were considered to be normal. It was ascertained later that the baby had developed a mild jaundice on the third day, but when examined again by one of us on the twenty-first day, he was apparently normal.

The case demonstrates that an occasional "Rh-positive" mother may be immunized by an "Rh-positive" baby, owing to a difference in Rh subtypes, and that unless tests for agglutinins are made, the presence of atypical agglutinins may remain unsuspected and undetected, particularly in a case like this, in which the baby was born apparently normal, and except for a transient jaundice, remained normal. It also shows that tests for the Rh factor in mothers and babies should be made with several anti-Rh sera capable of detecting possible differences in Rh subtypes between mother and baby. Further, it shows the need, in the case of all parous women requiring blood transfusion, for careful cross-compatibility tests, which should be made only by responsible and trained laboratory workers, and we stress again the need in all cities for a pool of known "Rh-negative" donors.[1]

Although Mrs. B. was "Rh-positive", she could have received blood only from an "Rh-negative" donor or a person of the same Rh subtype, Rh′, should a transfusion have been necessary. Had it been necessary to give the baby a transfusion, two alternatives would have been available: (i) "Rh-negative" blood, or (ii) the maternal cells thoroughly washed with sterile saline solution to remove all traces of antibodies, and then reconstituted in sterile normal saline solution, or, as has been suggested by Wiener (1944), mixed with the father's plasma, provided his plasma is A-B-O compatible. Wiener states that "for the treatment of the infant, transfusion of the mother's washed erythrocytes is the 'key which fits the lock', while Rh-negative blood acts as a 'skeleton key' that will 'fit almost all of the locks' ".

Subsequent tests, not detailed here, made with serum from Mrs. B. collected on June 16 and July 23, although not conclusive, suggest to us that Mrs. B.'s serum contains agglutinins anti-Rh and anti-Rh_2. In view of the histories of previous pregnancies it seems reasonable, therefore, to think that she had been immunized by a previous "Rh_1Rh_2" baby, that she had retained some anti-Rh_2 antibody for several years, and that she had been further immunized against the concomitant Rh element in the present instance in which the infant is "Rh_1". Recent tests suggest that this anti-Rh antibody is now disappearing, and if the above immunization theory is correct, it may account for the mildness of the infant's erythroblastosis, if we accept the fact that the child indeed suffered from the disease. Had this infant been unfortunate enough to belong to subtype Rh_1Rh_2 instead of Rh_1, his reactions to the maternal agglutinins would probably have been much more severe.

[1] Tested human anti-Rh sera suitable for establishing "Rh-negative" donor pools are supplied as a free service to approved laboratories by the Director of the Commonwealth Serum Laboratories, Melbourne, in cooperation with the Red Cross Blood Transfusion Service.

TABLE III.
Classification of the Rh Types in Mrs. B.'s Family.

Blood Sample from	Group and MN Type.	Reactions with Anti-Serum.			Rh Subtype.
		Rh_1.	Rh_2.	Rh.	
Mrs. B.[1]	OMN	+	−	−	Rh′
Baby B.	OMN	+	−	+	Rh_1
L.B. (10 years)	OM	+	−	+	Rh_1
J.B. (13 years)	OM	+	+	+	Rh_1Rh_2
J.F.B. (father)	OMN	+	+	+	Rh_1Rh_2
J.G.B. (grandfather—paternal)	OMN	+	+	+	Rh_1Rh_2

[1] The outcome of other pregnancies is detailed in the clinical record.

Summary.

The production of immune iso-agglutinins in an "Rh-positive" mother of subtype Rh′ by an "Rh-positive" baby of subtype "Rh_1" and/or by a previous baby of subtype "Rh_1Rh_2", has been demonstrated. The baby was normal at birth and showed no apparent manifestation of *erythroblastosis fœtalis*. It is thought, however, that his condition may be regarded as one of subclinical erythroblastosis. The case was discovered by accident, in that it was selected at random as one of several normal controls for a series of special tests. A brief review of the relevant literature concerning the subtypes of Rh is presented.

Acknowledgements.

We are grateful to Dr. A. S. Wiener, who made two anti-Rh sera available for classifying the Rh subtypes, to Dr. F. M. Burnet, who kindly brought the antisera from New York, and to Dr. Rachel Jakobowicz, who cooperated with us in determining the Rh subtypes for this paper.

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A CASE OF HYDATID CHOLEPERITONEUM.

By Douglas Robb,
Auckland, New Zealand.

Clinical Record.

J.I., a male patient, aged fifty-five years, a house painter, was admitted to hospital on November 10, 1944, with an enormous distension of the abdomen. Bile-stained fluid had been obtained by paracentesis by Dr. G. J. Frengley at another hospital shortly before. The patient had regarded himself as quite fit until seven weeks before his second admission to hospital, when he was suddenly prostrated with abdominal pain and vomiting. Seven days later his abdomen began to swell, and this distension had continued progressively. On first examination the distension was enormous, but the patient's general condition was surprisingly good. He was slightly anæmic, but not jaundiced and not wasted. Half a bucketful of greenish-yellow, turbid fluid was evacuated from the left lower quadrant of the abdomen by trocar and cannula, but this made little visible impression on the size of the abdomen. This fluid contained "bile, granular debris, many hooklets, and an occasional complete hydatid scolex". No daughter cysts or fragments of laminated membrane were recognized. The complement fixation test produced a positive result. No record of the performance of the Casoni test or of the presence of eosinophilia was made.

The patient had never suffered from urticaria or other anaphylactic manifestations. He had spent all his life in various rural districts of the North Island of New Zealand, carrying out such work as building and painting wool sheds. He was a bachelor, and no other member of the family was known to have suffered from hydatid disease.

The diagnosis was clearly choleperitoneum arising from a hydatid cyst cavity in communication with a bile channel. Operation was advised and carried out on November 18 under nitrous oxide and oxygen anæsthesia. A long right median pararectal incision was made, extending above and below the umbilicus.

The state of affairs revealed is shown in the accompanying sketch kindly prepared by Sir Louis Barnett (Figure I).

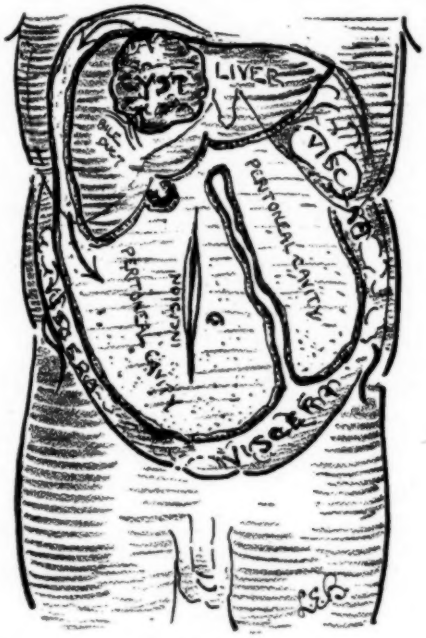

Figure I.

Diagrammatic sketch of condition found at operation, November 18, 1944. Rupture through vault of right lobe of liver of an old degenerated hydatid cyst; rupture of a bile duct into the cavity of the cyst; escape of cyst contents containing scolices, hooklets and bile into peritoneal cavity, leading to huge bilocular distension and to crowding of the viscera behind a thick membrane of encystment.

The right adventitious pouch was entered first, the left extending only to the iliac fossa, and being discovered towards the close of the operation; this was the pouch which had been punctured before operation. The right pouch was a continuous cavity extending from the pouch of Douglas to the dome of the diaphragm. It was lined by a dirty yellow, gelatinous membrane with a finely nodular surface like sago grains. It was about two millimetres thick, and histological examination of a biopsy specimen later revealed "well-formed fibrous tissue heavily infiltrated by chronic inflammatory cells". Whilst the exploration between the diaphragm and the dome of the liver was proceeding, still in this pouch, a hole with strong fibrous edges, about five centimetres in diameter, was felt leading into a cavity in the liver. From this was extracted a characteristic hydatid laminated membrane, quite necrotic but almost intact, forming a sphere eight to ten centimetres in diameter. The bottom of this cavity in the liver could be felt to be thin and easily accessible for drainage if necessary, just to the left of the gall-bladder. The adventitious membrane, particularly in the pelvis and mid-abdomen, could be separated with remarkable ease from coils of intestine and

other viscera, and was so separated completely up to the level of the umbilicus, before it was realized that it was not necessary to remove it. At that point the left pouch was discovered, and the operation was terminated by drainage of the left pouch, the remainder of the right pouch and the pelvis.

The operation was borne remarkably well, and though irregular fever continued for three and a half weeks, sulphonamides being given, the patient's general condition improved, and all wounds healed and drainage ceased without further intervention. Even the large cavity in the liver seemed to cause no trouble, as a plain skiagram six weeks later revealed no gas or fluid level.

Comments.

Hydatid choleperitoneum, first comprehensively studied by Dévé, of Rouen, is not common, and this case is unusual, in that it occurred in an old liver cyst which never developed daughter cysts, and which was operated on at a comparatively early stage after rupture.

In the surgical management the chief interest lies in the treatment of the adventitious peritoneal membrane. It need not be removed. Drainage only is necessary. This has been fully described in H. R. Dew's[1] book and by L. E. Barnett.[2]

The prognosis in this case is marred by two possibilities. (i) The adventitious sacs, and also the cavity in the liver, were so large and complicated, that at any stage one must be prepared to go back and drain an abscess resulting from residual infection. The surprise is that no such abscess requiring intervention has occurred in the first twelve weeks. (ii) Secondary cysts may grow from viable hydatid remnants in the adventitious sac wall. This is less likely in this case than in a similar case in which daughter cysts had already been extruded. The inflammatory infiltration of the wall, and the necrotic debris found in the sac, also suggest that this is perhaps not likely.

Acknowledgement.

I wish to express my appreciation of kindly comments and help from Sir Louis Barnett, to whom notes were sent for the Royal Australasian College of Surgeons Hydatid Registry, and also for the accompanying diagram.

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TREATMENT OF KERATITIS AND IRIDOCYCLITIS OF UNKNOWN ORIGIN WITH "NEOSALVARSAN" AND SODIUM SALICYLATE.

By ARTHUR LAWRENCE,
Melbourne.

Case I.

THE patient was a married man, aged thirty-four years. On August 3, 1934, he complained of inflammation of his right eye, of ten weeks' duration; visual acuity in the eye was $^6/_{36}$. The lower half of the cornea was white and semi-opaque. A few brown keratitic precipitates were present. The visual acuity of the left eye was $^6/_6$. General examination revealed no abnormality, and the Wassermann test failed to produce a reaction. I suggested to the patient's medical attendant, Dr. McColl (now deceased), to try (i) milk injections, (ii) "Novarsenobillon" injections, (iii) *Mistura Sodii Salicylatis*.

I examined the patient again on October 5, 1934. The visual acuity of the right eye was $^6/_6$, and the cornea was almost clear. Some spots of pigment were still present on the lens, and a few opacities were seen in the cornea; but the difference in the cornea was dramatic. The fundus was clearly seen, and was normal.

On April 29, 1943, the patient returned to thank me. The visual acuity of both eyes was $^6/_6$. Examination with the slit lamp revealed a faint remnant of the keratitic precipitates in the right eye.

Case II.

The patient was a married woman, aged thirty-one years, who had three healthy children and had had no miscarriages. On February 4, 1941, after appendicectomy, her left eye became painful whilst she was in hospital; the eye remained red. Examination revealed that the visual acuity of the right eye was $^6/_6$, whilst that of the left eye was restricted to perception of hand movements. She was admitted to the Eye and Ear Hospital for investigation. All tests produced negative results. The diagnosis of iridocyclitis with corneal opacity was made, and the patient was sent home to the country, to the care of Dr. R. D. Buntine, of Korumburra, who gave her injections of "Novarsenobillon", and *Mistura Sodii Salicylatis*. On April 29, 1941, the visual acuity of the left eye, with a correction by a concave 1·25 diopter cylindrical lens, was $^6/_9$. On June 3, 1941, the visual acuity of the right eye, with correction by a concave 0·25 diopter cylindrical lens with its axis at 20°, was $^6/_{4·5}$. That of the left eye, with correction by a concave 1·0 diopter cylindrical lens with its axis at 150°, was $^6/_{4·5}$. After the injections, the condition of the eye improved under treatment with *Mistura Sodii Salicylatis*, which was continued till July 29, 1941.

Case III.

The patient was a married woman, aged forty-four years. She was examined on January 11, 1944, when she complained that she had had five attacks of iritis in the left eye during the past sixteen months. The visual acuity of the right eye was $^6/_6$; with the left eye she was able to count fingers at a distance of three feet. The patient was referred to me by Dr. K. Smith; she was prepared to undergo excision of the eye. Examination revealed corneal opacities and irregularity of the pupil of the left eye. Treatment with "Novarsenobillon" and *Mistura Sodii Salicylatis* was ordered. The Wassermann test failed to produce a reaction. Dr. Smith gave the "Novarsenobillon". On February 12, 1944, the visual acuity of the left eye was $^6/_{60}$; on February 25 it was $^6/_{18}$; and on July 4 it was $^6/_9$.

Comment.

It may be argued that these are cases of syphilis. I can only say that neither the Wassermann nor the Kahn test produced a reaction in any case, and that there was no other clinical evidence of syphilis. My original idea in using "Novarsenobillon" was along the following lines: "Here is an apparently lost eye. 'Novarsenobillon' and sodium salicylate have been successfully used in cases of sympathetic ophthalmia. Why not try it in these cases?" The result has been so striking that it seems worth while passing on the experience. All three patients had been examined by other oculists and given a bad prognosis—so bad, indeed, that in one case excision of the eye had been suggested for the relief of pain.

TRAUMATIC ANEURYSM OF THE ULNAR ARTERY.

By ALBAN GEE, F.R.C.S.,
Lieutenant-Colonel, Australian Army Medical Corps.

THE following case is reported because of the rather unusual and protected site or origin of a sacculated aneurysm caused by repeated minor traumata.

Clinical Record.

Sapper M., of a water transport company, was admitted to hospital on January 31, 1944, complaining of a painful lump in the palm of his left hand. The history was that he had noticed no abnormality till three months earlier, when a small swelling developed in the palm of his hand near the wrist; it was painful and interfered with his work. The swelling was increasing in size. The pain had the character of a constant ache, but was much worse when the lesion was knocked or bumped. It did not radiate and was unaffected by movements of the forearm and hand. Further questioning elicited the fact that the patient's present job was on small craft, and in the maintenance that this entailed he often knocked his hypothenar eminence. Three months previously he had had to man the pumps intermittently for nearly four days. During this period his hand had become very tender and a small swelling had appeared. He had carried on his work since then with increasing difficulty. He was now anxious to obtain treatment, as he was shortly to be required for an important mission. In civilian life he was a fitter by trade, and had been on a job where he was continually knocking this same area of his left hand on

a board. No swelling had been noticed previously, and he had suffered no disability.

Examination revealed a rounded swelling, one inch long by three-quarters of an inch wide, on his left hypothenar eminence. It was tense, cystic and non-lobulated. There was no visible pulsation, but a pulsation corresponding to the arterial pulse wave could be palpated and appeared to be expansile. The mass could not be moved either from side to side or in a longitudinal direction, and appeared fixed to the deeper tissues. Pressure immediately proximal to the tumour caused a loss of pulsation, but little, if any, change in its tenseness and size. Pressure on the swelling itself, even while proximal pressure was also applied, caused no diminution in size.

Tenderness was elicited only on firm pressure. No thrill could be felt, nor was there any bruit on auscultation; flexion and extension of the fingers and wrist were normal. There were no signs of muscle wasting or of nerve involvement. No abnormality could be found in the other systems of the body.

The difficulty in diagnosis was to decide (i) whether the swelling was part of the ulnar artery itself, (ii) whether the pulsation was being transmitted through a tumour, or (iii) whether a tumour had lifted the artery forward. The third possibility was excluded, as the pulsation seemed not to be limited to the line of the vessel and was spread over a wider area.

There were points both for and against the first two possibilities. Clinically an aneurysm seemed most probable; but from the history of repeated local traumata, an adventitious bursa overlying the artery seemed as likely as an aneurysm in a part of the vessel that was well protected. It was decided to aspirate the swelling under local anæsthesia. Pressure was applied both proximally and distally, and a needle was inserted in two different directions. Nothing was evacuated even when the pressure points were released.

Operation was undertaken. Under general anæsthesia, a longitudinal incision was made over the swelling. When the *palmaris brevis* and volar carpal ligament were incised a pulsating tumour was seen, which proved to be an aneurysm of the ulnar artery. It was one inch in length, three-quarters of an inch in breadth, and half an inch in depth. The ulnar nerve was running down the medial side and attached to the aneurysm. When dissected out, the aneurysm was lying between the pisiform bone and the hook of the hamate bone, and extended distally almost to the division of the artery into deep and superficial branches. Ligatures were applied proximally and distally and the aneurysm was removed.

Examination of sections of the aneurysm revealed that it was of the typical sacculated type, with a septum dividing it into two compartments, each containing blood clot. Puncture marks showed that the needles had entered these compartments.

Convalescence was uneventful, except for a slight serous oozing and some signs of diminished blood supply to the wound edges for the first week.

Acknowledgement.

I am indebted to the Director-General of Medical Services for permission to report this case.

Reviews.

A TEXT-BOOK ON SURGERY.

"SURGERY", by C. A. Pannett, may well herald a new era in English text-book production.[1] It is modelled a little on the lines of American text-books, and appears to be inspired by Mr. Churchill, for throughout it is written in his clear unstilted everyday English which anyone can understand and which avoids unnecessary "Latinisms" where Anglo-Saxon words are available. Thus, when he is describing the anæsthetic risk in patients with intestinal obstruction, the author writes: "A general anæsthetic is associated with the risk of the patient drowning in his own vomit." While on the subject of intestinal obstruction, however, he includes none of the modern work on the use of serum in the presence of a low serum protein level, or on the employment of the Miller-Abbott tube.

Clear black and white illustrations show pathological conditions and clinical procedures, photographs not being included. The text on fractures is particularly well illustrated.

Clear diagrams showing the mechanism of production of Erb-Duchenne's and Klumpke's paralyses are part of a chapter on nerve lesions. There is a particularly good chapter on diseases of the spine showing characteristic positions and diagrams of the X-ray photographs and of plaster jackets employed. Surgery of the hand takes up one chapter, but a method of suturing tendons is given which results in a knot between the anastomosed ends. A chapter on diseases of joints is notable for its very fine black and white illustrations of tuberculous knee joint, wrist joint and shoulder joint, and Charcot's joints. Internal derangements of the knee joint are particularly clearly described by means of illustrations.

This book may be summarized as being clear, very well written, and conservative to the point of being a little behind the times. An appendix is included at the end of the book, which mentions in short paragraphs penicillin, the sulphonamides, proflavine *et cetera*.

THE RORSCHACH TEST.

"THE CLINICAL APPLICATION OF THE RORSCHACH TEST", by Bochner and Halpern, provides a clear and concise description of the basic features of the test.[1] It is a book most helpful to the clinician or technician, unconversant with the test yet wanting to know what it is, how it is done and what it reveals in the realm of psychological medicine. It is of less use to those seeking a discussion on the detailed and debatable aspects of the test, or to the clinician desiring to know in what mental disorders the test shortens or materially assists the usual clinical approach.

In the opening chapters of the book the method of giving and scoring the test is recorded. In view of the introductory nature of this work, this section would have been enhanced by the inclusion of a reproduction of the actual ink blot figures used for the test.

The major part of the book is devoted to a description of what the test shows in the different psychiatric disorders. Those illustrated include mental defectiveness, hysteria, obsessional states, schizophrenia and organic disease. In each of these reactions the results of the test in an individual case are described and discussed. This account is followed by a brief summary of the clinical history. This is perhaps the weakest section of a book portending to give the clinical import of the test. The clinical records could have been more detailed, or even set out before the test results. These could have been discussed more fully as to their value in assisting or giving added information to the clinical history. In this manner the rightful place of the test as an adjunct to the clinical approach would be emphasized. It would prevent the development of an improper balance between the fundamental methods of medicine and the ancillary procedures of the laboratory. It would have fulfilled more adequately the title chosen for this book, "The Clinical Application of the Rorschach Test".

FRACTURES.

IN September, 1943, we reviewed the first edition of a South African book, "Fractures and Fracture Treatment in Practice", by K. Colsen. We stated that we had read the book through with keen appreciation and approval, and that as a short everyday handbook we had seen nothing better or quite as good. It is evident that others have thought the same about it, for now, after about eighteen months, we have to give a similar welcome to it in a second edition.[2] This edition is a little longer than the first, and contains more illustrations. We hardly want it to expand greatly in size, for if it gains in one way it may lose in another. We commend it again in the same terms as before, and again we congratulate Dr. Colsen and the Witwatersrand University Press.

[1] "Surgery: A Textbook for Students", by Charles Aubrey Pannett, B.Sc., M.D., F.R.C.S.; 1944. London: Hodder and Stoughton Limited. 10" x 6¼", with many illustrations. Price: 35s. net.

[1] "The Clinical Application of the Rorschach Test", by Ruth Bochner, M.A., and Florence Halpern, M.A., with an introduction by Karl M. Bowman, M.D.; 1942. New York: Grune and Stratton. 8½" x 5½", pp. 225. Price: 21s.

[2] "Fractures and Fracture Treatment in Practice", by K. Colsen, M.D.; Second Edition Revised; 1944. Johannesburg: Witwatersrand University Press. 8½" x 5½", pp. 160, with 163 illustrations. Price: 12s. 6d. (plus 4d. postage).

The Medical Journal of Australia

SATURDAY, APRIL 21, 1945.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

FRANKLIN DELANO ROOSEVELT

The announcement of the death of Franklin Delano Roosevelt, President of the United States of America, has been a heavy blow to the allied nations and to all in every country who stand in need of material and moral aid. His work, though not finished, will live after him, and the whole world, with the American people, will reap the benefit of his understanding, his foresight and his wisdom. His name will go down to history as that of an upright and honourable leader, a fearless administrator and a great humanitarian. The medical profession of Australia joins with the people of the Commonwealth and the Empire in paying homage to his memory.

THE MEETING OF THE FEDERAL COUNCIL.

ONCE again the Federal Council of the British Medical Association in Australia has met and has dealt with an agenda paper covering a great range of subjects. The report of the meeting published in this issue is lengthy, but when it is remembered that the discussions lasted for four days the report cannot be described as too long. As has been pointed out on previous occasions, the account of the meeting published in this journal is an attempt to give members a comprehensive idea of the matters considered. It is not like the minutes in that the several items are linked up with what has been done at previous meetings so that readers will have some understanding of what has led up to each subject discussed. Salient features of the discussions are reported so that differing points of view may be appreciated. In the circumstances in which Australian medicine finds itself today it should not be necessary to urge members of the Branches to study the report provided for them. At the recent meeting no new policy or principles were laid down. The Federal Council had already determined its attitude towards such matters as the health policy of the Australian Government, the *Pharmaceutical Benefits Act*, contract practice and a Federal agreement covering it, the medical coordination committees, research and so on. What was done was to reaffirm certain attitudes, to look for means of extending knowledge about them, to try to remove misunderstandings and to secure uniformity of action among members of the Branches. Some aspects of the subjects discussed may be emphasized or elaborated.

The subject that will doubtless be of most immediate concern to the members of the Branches is the forthcoming introduction of the *Pharmaceutical Benefits Act*. The Federal Council had long before decided what its attitude to this strangely conceived measure was to be. What still remains for certain members of the Branches is that they shall appreciate to the full the reasons of the Federal Council's objection to the act, that they shall understand what the words "refusal to cooperate" mean, and that they stiffen their own resolve to follow the Federal Council's lead. At the risk of our being wearisome to those who understand and appreciate them, the reasons for the Federal Council's objections must again be mentioned. In the first place the act purports to provide a benefit to every member of the community, but the Federal Council holds that in point of fact it does not do so. The community for purposes of the act may be divided into two sections. The first group includes those whose pharmaceutical requirements come within the limits of the official formulary and who will be entitled to the benefits of the act. The second group includes those whose pharmaceutical requirements do not come within the limits of the formulary and who will not be entitled to the benefits of the act. This second group of persons will have to pay for their medicines when the prescriptions, which their doctors think they should have, do not follow the pattern of the formulary. There is thus a financial discrimination. This would not matter much if all the people who had to pay were able to pay. In other words, the provisions of the act are in favour of the man who has enough money, and penalize the man who has not. From the patient's point of view this is a hardship and is unjust. The inevitable consequence is that the doctor will be placed in such a position that his freedom to prescribe exactly what he thinks his patients need will be in jeopardy. This is unjust both to the doctor and to the patient. The Federal Council as a body does not object to the use of a formulary in medical practice. It recognizes full well that by far the larger majority of prescriptions needed by patients can, with perfect safety to the patient and with no loss of therapeutic value, be made to fit in with a comprehensive and carefully drawn formulary. In fact some few years ago it was one of the bodies which issued the "Australian Pharmaceutical Formulary", a publication widely used before the shortages of the present war made certain curtailments necessary. Again, the Australian War Pharmacopœia, designed to meet the special needs of the times, has been widely used. The point about what are known as the "A.P.F." and the "A.W.P." is that their use is not hedged round by certain conditions that are not in the interests of the patient.

The same statement also holds true of course of formularies used in hospital practice and in friendly society lodge practice. The suggestion has been made that the removal of the restrictions in the act surrounding the use of the formulary would result in extravagant prescribing and in the piling up of enormous costs. Even in the practice of the act as at present constituted extravagant prescribing could occur. The reply is that made by the General Secretary of the Federal Council that extravagance could be checked by the appointment of a committee of medical practitioners who would act as a controlling or referee body. The conditions surrounding the use of the formulary are the chief grounds for objection that the Federal Council has to the *Pharmaceutical Benefits Act*. The other objections have to do with the penalties to be imposed on doctors for certain procedures to which in certain circumstances no exception can be taken, the form of administration of the act, and the opportunity provided by the act for the introduction of a nationalized medical service. Readers will note the Federal Council's statement to the Minister that it has no desire to deprive the patient of free medicine. They will also note the assurance that the medical profession will cooperate with the Government if the features of the act described by the Federal Council as objectionable are removed. This brings us to the meaning of the words "refusal to cooperate". There appears to be current among some members of the Branches an idea that if a practitioner uses the formulary and writes his prescriptions on the prescribed forms when it suits him to do so and refuses to do these things in other circumstances, he is not cooperating with the Government. Refusal to cooperate means a refusal to comply with any of the provisions of the act in any circumstances whatever. There can be no half-and-half business about this. To write even one prescription on the prescribed form in accordance with the directions for the use of the formulary is to cooperate with the Government. It is non-cooperation for which the Federal Council asks. Since the Minister and his supporters in Parliament declare quite frankly that the act is not intended to benefit the health of the people in any way, there can be no complaint against the profession on the ground of health if it refuses to do what the Government asks it to do.

One of the most important speeches at the Federal Council meeting was made by Dr. A. J. Collins when he described the work of UNRRA. It is far too easy to pour cold water on the work that is to be done by this body. Candid criticism sometimes has the effect of causing a renewal of interest and effort. UNRRA has been criticized in Australia, and everyone who, like Dr. Collins, appreciates the overwhelming problems that will emerge in European and Asiatic countries after the fighting has ceased, must hope for an awakening of interest. Hope is not enough. Action is needed. It will not take place unless many persons in the community are aware of the need and are prepared to do something about it. What Dr. Collins said about the need for a world survey of doctors should not be allowed to pass unnoticed. We may be sure that he has had something to say on the subject in the councils of UNRRA. There is no doubt that even if the details of the needs of each country were clearly known, there would be difficulties in the way of training men and women for medical service in the areas. When we are told that there are in the Australian Army some two thousand men who want to study medicine, we may safely conclude that among them would be found quite a number, fired by a spirit of adventure if not by a love of humanity, who would enrol for this work. To think of difficulties and to hesitate because of them is to be faint-hearted. This is a matter not for politicians, but for statesmen—men who can look ahead, who can think along international and humanitarian lines, and who can see Australia accepting her full share of the post-war rehabilitation of the nations. If UNRRA is to function successfully it must assess the requirements and make them known. Statesmen will then be able to act.

From rehabilitation of the nations it is simple to pass to rehabilitation of our own service personnel, and of these, medical officers must be the particular care of the practising medical profession. This subject has been discussed at some length in these pages on previous occasions. The provision of post-graduate courses of study and training is part of it. Attention should be drawn on this occasion to the letter from the Central Medical Coordination Committee to the Federal Council in which it was suggested that members of the Branches should make liberal offers for partnership and assistantship appointments to those who have served with the fighting forces. The word "liberal" should be emphasized. Already one or two signs have appeared that the outlook of prospective principals in the matter of these appointments will not invariably be liberal. There are many reasons why assistantships and partnerships should be found for servicemen by private practitioners, and practitioners know what they are. When further inquiries are made among members of the Branches in the not too distant future, as they undoubtedly will be, all these reasons should be remembered. Those who are short-sighted, selfish and niggardly may some day have cause to regret their self-centredness if rehabilitation of medical officers has to pass into the hands of a governmental authority. In regard to post-graduate education of service medical officers, far-reaching plans have been made in some of the States by bodies outside the services, and a good start has been made by these bodies to help officers while they are still on service. What will happen after the discharge of service officers will depend to a large extent on the rate at which demobilization is carried out. In this matter and in the provision of opportunities for study while officers are still serving, the medical directors of the services can be relied upon to do what is in their power and to do it with discretion.

The remaining matters to which the attention of readers should be specially directed include the progress made in regard to the introduction of the Federal Common Form of Agreement, an instrument which will, we trust, make for harmonious working and efficiency in friendly society lodge practice, a form of service which has been and still is of the greatest benefit to members of the community who are eligible to be included in its scope. The efforts that are being made to secure nurses and domestic assistance for the running of hospitals must be applauded. It appears that only tireless importunity will be effective in this sphere. The formation of two more special groups—covering orthopædics and physical medicine—is a sign of progress.

Current Comment.

THE MANAGEMENT OF PRIMARY TUBERCULOSIS.

Some time ago attention was drawn in these pages to the problems raised by the recognition of minimal tuberculous lesions in service personnel. Stress is rightly laid upon the need for the early recognition of pathological states, but, as all clinicians are acutely aware, the real difficulties arise when disposal and treatment must be provided. In clinics devoted to the study and care of pulmonary diseases it has been long recognized that great good can be done by discovering evidences of primary tuberculous infection in contact children. Efforts are chiefly directed towards the amelioration of the conditions of home care and of nutrition, and attempts are made to follow the medical careers of such children so that early recognition of the secondary tuberculous disease complex will enable prompt treatment to be instituted. Milton Levine has raised again the very important question of the actual handling of children with signs of primary tuberculous infection of the lungs.[1] When a contact child is found to have evidence of primary tuberculous infiltration of the parenchyma of the lungs, what are we to do? Shall we regard this active infection as one which demands rest in bed, or in fact regard the child so infected as an adult *in petto* and requiring the same treatment as for the secondary adult type of infection? Or shall we base our advice on the view held by many physicians that such measures do little if anything to alter the course or outcome of a primary infection? Levine quotes Wallgren, who advises that the temperature and sedimentation rate be used as a guide, and that children showing evidence of active infection should be kept in bed until these signs of activity have subsided. Myers, on the other hand, is quoted as having little faith in sedimentation rates, and his view is that except for the treatment of fever by rest, as for any other infection, there is no need for strict bed rest, since the prognosis is not altered thereby. Levine has assembled the results of a study on over 1,000 children in New York between the years 1926 and 1942. The standard for diagnosis was accepted as being the demonstration by serial skiagrams of calcification in parenchymatous pulmonary lesions found in children who reacted to the intradermal tuberculin test. Gross parenchymatous lesions were found in 90 children, 58 of whom were under the age of one year. The remaining 63 children, classifiable by their age as potentially ambulatory, were allowed to be ambulatory in fact; in short, as a medical Micawber would say, they were allowed to run about as usual unless the rectal temperature exceeded 101° F. All these children were followed for a period of at least five years, and no evidence could be discovered that their management did them any harm. Of the babies in whom the disease was discovered before the age of one year, one-third died of tuberculosis. This is not relevant to the present inquiry, but illustrates the sinister significance of early pulmonary infiltration in young children. In the older group it was found that the average time for calcification of the pulmonary focus was 21·1 months. Wallgren, in his series of children treated by bed rest, found that calcification became manifest in about twelve to eighteen months and became complete after a total lapse of two to three years after the initiation of the lesion. Of course, as Levine points out, the Swedish series may not present a compete foil to the New York series, but at least it would appear that there was no undue lengthening of the course of the primary complex in the latter.

Further analysis of Levine's cases indicates that it is the age at which childhood infection occurs that is the important factor in mortality in children from tuberculosis during the early years. Indeed it seems fair to assume that the early appearance of a pulmonary lesion is in itself evidence of massive infection or of failure of the infant to establish a sufficient immunity, or both. Levine points out that numerous investigators have stressed the importance of the intimate contact of babies with their parents, and his figures show that the scales are heavily weighted against infants whose mothers have active pulmonary tuberculosis. It is more than twice as dangerous for a baby to have a tuberculous mother than a tuberculous father. Levine concludes that rest in bed during a primary infection with tuberculosis is necessary only during any febrile period. Indeed, when one considers the serious side effects that prolonged and repeated episodes of bed rest may have on a child's life, it would seem reasonable to demand sound proof for its necessity before denying such children that degree of activity which is so necessary for their physical and mental well-being.

[1] *American Journal of Diseases of Children*, December, 1944.

SULPHONAMIDES AND RESPIRATORY INFECTIONS.

The capacity of certain bacteria to become "sulphonamide fast" promises to become a factor of some importance in some infectious diseases. In gonococcal infections, for example, it is disconcerting to find that gonococci may sometimes develop resistance to sulphonamide drugs, and that these types not only retain this quality through succeeding generations, but lose none of their virulence and infectivity. In the case of respiratory disease this aspect of the complex bacteriology of the common acute infections has received considerable attention, and the general trend of opinion at present seems to be that the risk of inducing sulphonamide fastness in certain bacterial groups must be thought of when sulphonamides are used for treatment or prevention. The question is of importance in connexion with epidemics such as the common cold and influenza. M. Siegel and L. A. Julianelle have published a series of studies on the epidemiological results of sulphadiazine used as a prophylactic.[1] They were not so much concerned with the favourable results recorded following the use of this and similar drugs on the complications of acute respiratory infections as with the effect on possible epidemic conditions. They used in their survey the inmates of an institution for the feeble-minded. This institution was closed, in the sense that its inmates did not mix with the outside world to any great extent and led a controlled life. The subjects of the study were all children. A dose of one gramme of sulphadiazine daily was given to the test group; this dose was later increased to two grammes, and a control group was also observed. No toxic reactions were noted, though sulphadiazine crystals were commonly observed in the urine and also a few red blood cells. No significant difference was observed between the two groups, so that no evidence was obtained that the drug protected the treated children to any extent from the incidence of respiratory infections. It must be admitted, however, that very few such infections occurred in the control group during the test period.

This shows how necessary it is to have long observation of large numbers of persons under all manner of conditions before accurate conclusions can be drawn. Other findings in these experiments were of greater interest. Striking changes were found in the bacterial flora in the throats of treated children. The Gram-negative cocci disappeared rapidly, but this was only a transitory action, as these cocci reappeared in their original numbers, and with some increased tolerance for the drug. The Gram-positive cocci were not numerically affected, but there did seem to be some inhibitory action on hæmolytic streptococci. The pneumococci showed some selective action on the various types, and this was specially studied. After prolonged administration of sulphadiazine to physically normal children serial cultures from the throat show an increase in resistant types of pneumococci. The strains which did not acquire this resistance were eliminated, but the resistant strains retained their specificity and their virulence. After administration of the sulphadiazine had been discontinued, the distribution of pneumococcal types tended to revert to its previous state.

It will be interesting as time goes on to see the successive phases of this war of man *versus* bacteria; impartial Nature probably still has some surprises.

[1] *Annals of Internal Medicine*, January, 1945.

Abstracts from Medical Literature.

GYNÆCOLOGY.

The Effect of Posterior Lobe Pituitary Gland Fractions on the Intact Human Uterus.

CHASSAR MOIR (*The Journal of Obstetrics and Gynæcology of the British Empire*, June, 1944) reports the results of a series of researches which were undertaken under the direction of the Nuffield Department of Obstetrics and Gynæcology in the University of Oxford. Two active principles of the posterior lobe of the pituitary gland, which have entirely different properties, were used. One has the property of stimulating the plain muscle of the arteries and certain abdominal viscera; the other is exclusively concerned with the stimulation of the plain muscle of the uterus. The former one is the vasopressor fraction and is usually known by the trade name of "Pitressin". The latter is the oxytocic fraction and is known under the trade name of "Pitocin". Both names have been given by the firm of Parke, Davis and Company. Physiologists speak of them as vasopressin and oxytocin. Up to the present it has generally been supposed that the physiological action of "Pitressin" is unrelated to uterine activity, but work done in this paper shows that this fraction does in fact also have an important stimulating effect on the human uterus, which, however, varies in degree according to the physiological state of that organ. It has always been known that "Pitocin" has a stimulating effect on the uterus. In reviewing previous work, the author points out that results obtained with the excised uterus of a pregnant rabbit, the isolated uterus of the non-pregnant guinea-pig, and the intact human uterus during labour, show different reactions. In certain experiments the results were almost directly opposite to one another. The author has followed up the work of Bourne and Burn by inserting a sterilized small balloon in the pregnant uterus, and from this reading off the pressure curve made on the appropriate apparatus. Observations were made on both the pregnant and non-pregnant uterus with both the "Pitressin" and "Pitocin" fractions. The author gives a series of graphs in the original article showing the results obtained. It was found that the human uterus reacts according to its physiological state. In the non-pregnant uterus there is a variation even as regards the phase of the menstrual cycle. The reaction of the uterus also varies according to the physiological state of the uterus at the time of the test. The non-pregnant uterus responds to pituitary extract at every phase of the menstrual cycle, although the response is most active immediately before or soon after menstruation. During early pregnancy the response to pituitary extract is weak, but it is stronger if the uterus is emptying itself of its content during an abortion. The response of the pregnant uterus to "Pitocin" was very strong during parturition and during the early stages of the puerperium, but much weaker in late pregnancy and after the sixth day of the puerperium. The response of the non-pregnant uterus to "Pitressin" was very strong, but there was no response to "Pitocin", while the uterus during early pregnancy responded much more to "Pitressin" than to "Pitocin". It was also observed that suckling had a powerful effect on the uterus, stimulating it strongly to contraction.

The Use of the "Sump" Drain in Peritoneal Infection.

W. EMORY BURNETT, GEORGE P. ROSEMOND AND H. TAYLOR CASWELL (*The Surgical Clinics of North America*, December, 1944) describe a new method of drainage of purulent material from the pelvis or abdominal cavity. After reviewing the general objectives of surgical drainage and the various methods which have been used, the authors point out that most methods of drainage are unsatisfactory. The drainage tubes are soon shut off by adhesions and give further trouble later on. They refer to a drain which was designed by W. Wayne Babcock in 1936 which involves the principle of a "sump". The drain consists of two tubes of stainless steel, the outer one being large enough to take the smaller one inside it. The outer drain contains many perforations, none of them more than two millimetres in diameter. The smaller inner tube is drained by a small motor driven by electricity. The authors have treated patients with severe peritonitis who have an obvious abscess in the lower part of the abdomen. After treating shock with plasma, blood, fluids and adrenaline, they open the abdomen under local anæsthesia and insert the "sump" drain into the pelvis. It is anchored to the skin with a wire suture. Sulphonamides may be used or omitted. The authors recommend passing the sump right down to the bottom of the pelvic cavity. The advantages claimed by the authors are that the drain, being made of stainless steel, causes no irritation to the tissue; it can be placed in the most dependent part of the infected cavity; it drains away only liquid exudate and does not make any suction against the bowel, omentum or soft tissue. After three or four days the pelvic drainage is usually clear and the tube may be removed. The authors claim that this is a very distinct advantage in drainage and report a series of 96 cases of appendiceal and pelvic abscess in which this drain was used with a drop in mortality from 35% to 9·6%.

Accelerated Post-Partum Involution of the Uterus with Vitamin B Complex Therapy.

LEONARD H. BISKIND AND MORTON S. BISKIND (*Western Journal of Surgery, Obstetrics and Gynecology*, June, 1944), working in the departments of obstetrics and gynæcology in the Mount Sinai Hospital, Cleveland, Ohio, and the endocrine laboratory and clinic in the Beth Israel Hospital, New York, undertook a series of investigations on the assumption that post-partum uterine subinvolution is related to excess œstrogen and that this excess is due to failure of destruction in the liver owing to deficiency of factors of the vitamin *B* complex. They took two groups of pregnant women. One group was maintained on an average diet; the other received substantial supplements of vitamin *B* complex during pregnancy. In the latter group there were no cases of poor involution and only three cases of moderate involution. In the majority of cases excellent results were obtained. The authors conclude that a supplement of vitamin *B* complex during pregnancy materially hastens involution and lessens the incidence of subinvolution with its attendant sequelæ. They believe as a result of this study that the current teaching in text-books that incomplete post-partum involution of the uterus is considered to result primarily from local pathological conditions in this organ, is wrong. They hold that it is due to a systemic physiological disturbance, secondary to a nutritional deficiency occasioned by the increased metabolic demands of pregnancy, which deficiency, in turn, results in failure of the liver to inactivate œstrogen. They suggest that this correction in diet may be a factor in enabling women to get up earlier and indeed to be up in three or four days after confinement.

Rectal and Colonic Complications of Pelvic Irradiation.

H. I. KALLET AND M. J. THORSTAD (*Surgery*, June, 1944) discuss the various complications involving the rectum and lower part of the colon which may follow irradiation of the *cervix uteri* and other pelvic organs. Irradiation of malignant lesions of the cervix is a recognized procedure, and the serious nature of these lesions justifies the risk of subsequent bowel troubles, but the possibility of such bowel complications should be borne in mind when irradiation is recommended for benign lesions in the pelvis. The most common intestinal complication is a procto-sigmoiditis of varying intensity. Symptoms may appear shortly after the radium application and reach their maximum six or eight weeks later. Diarrhœa and tenesmus with frothy stools and increased mucus are prominent symptoms. There may be abdominal cramps and defæcation is unsatisfactory. There is at times a small amount of blood in the stools. The fæcal discharges are irritating and may lead to perianal excoriation, marginal infection, ischio-rectal abscess and fistula. Hæmorrhoids may be aggravated and thrombosis may occur. On examination the sphincters are usually spastic. Proctoscopy may reveal œdema and hyperæmia, and in more serious cases eschar and ulcer formation may occur. The patient's condition becomes miserable. Rest is essential, and a non-irritating though adequate diet should be given. Codeine is a suitable sedative. Injection of the sphincter with an oil-soluble anæsthetic agent may relieve the spasm and tenesmus. Cod liver oil instillations into the rectum are helpful. If enemata are needed "Petrolagar" and water are effective as the enema fluid. In favourable cases the condition subsides, though the mucosa may remain easily damaged, leading to the appearance of drops of blood in the stools for months afterwards. In addition to this type of reaction of a more or less acute nature, another sequel of irradiation is an extensive slow fibrotic reaction throughout the pelvic tissues leading to a slow progressive chronic intestinal obstruction appearing over a period of months or years. Where this "entrapment" is of mild degree, it may

be controlled by low-residue diet and the administration of mineral oil. In more serious cases, laparotomy may show that the bowel can be freed from the mass of adhesions, but in most cases colostomy will be needed. In some cases the onset of bowel symptoms will raise a suspicion of recurrence of the growth in the recto-vaginal septum or elsewhere. Biopsy will usually make the diagnosis clear. If growth is found, further irradiation may be indicated, but the danger of reapplication must be considered. Occasionally, surgical removal may be possible, but in many cases colostomy will be necessary. One of the most distressing sequelæ of pelvic irradiation is the formation of a recto-vaginal fistula. In small fistulæ, control may be possible by making the patient constipated, the hard fæces failing to pass through the small opening. Most patients will, however, need colostomy. Plastic operations on the fistulæ are usually not satisfactory, as the blood supply is poor and healing delayed.

OBSTETRICS.

The Clinically Suspect Pelvis and its Radiographical Investigation.

MEARS KENNY (*The Journal of Obstetrics and Gynæcology of the British Empire*, August, 1944) describes the results of the radiographical investigation of 1,000 patients with a clinically suspect pelvis. The patients examined, who were mostly in the last two weeks of pregnancy, included those who had evidence of pelvic contraction obtained by clinical pelvimetry, cephalopelvic disproportion, malpresentation and clinical evidence or a history of bony disease of the pelvis, spine or hips; they also included those with a history of previous prolonged labour and operative delivery. During the six years in which the investigation was carried out 10,000 patients were delivered; 94·8% were delivered spontaneously. That there is an overlap or some wasting of X-ray plates is admitted; on the other hand, included in the series were some women who had an X-ray examination in the second pregnancy, following an unpredicted disaster at the first delivery. Complete radiographic examinations were made of the first three hundred patients. Both the shape and the size of the cardinal diameters of the pelvis became manifest. By careful examination of the plates the author was able, when national economy necessitated restriction on the use of plates, to gain the necessary information from an antero-posterior view and a lateral view. As time went on the conviction was reached that shape rather than size was the best guide to prognosis. In the 1,000 suspect cases 34·8% of pelves were gynæcoid; 11% were gynæcoid-android; 20% were android; 25% were android-gynæcoid; 6·4% were pithecoid (anthropoid); 1·8% were platypelloid; 0·6% were pathological types. An attempt was made to correlate body build to pelvic type. The narrow sloping shoulders, slender waist, the hips rounding from waist to knee, the slim legs and ankles were found in 67%. The thick-set woman with thighs running straight down to thick ankles was associated with the android type of pelvis in 86 cases out of 106. The author applies the term pithecoid to the type described by Molloy as anthropoid; the people are usually tall, long-headed and wide-shouldered with narrow flanks and long slender limbs. It was further noted that the women of the android and android-gynæcoid type show the most personal and familial dysfunction of the endocrine system, menstrual disorders, sterility *et cetera*. If the gynæcoid pelvis is taken as unity, those with the android type are more than twelve times likely to develop the mild and eight times more likely to develop the severe forms of toxæmia; this tendency to obstetrical trouble is carried on from the antenatal periods through labour to the puerperium. Among the 128 *primiparæ* with android pelves, operative intervention was required by 108. Cæsarean section was performed 46 times. The next most sinister obstetric history occurred in the android-gynæcoid type; of the 105 *primiparæ* only 18 were delivered spontaneously. Cæsarean section was performed 25 times. The author states that small external measurements have been found in both small and large pelves. There was constant relationship between the radiographical and clinical measurements. From the examination of the detailed report of the incidence of operative interference in various types of pelves, it will be seen that the android pelvis plays the most sinister part in the causation of dystocia.

Diagnosis and Treatment of Hæmorrhage in Late Pregnancy.

ARTHUR C. BELL (*The Practitioner*, January, 1945) discusses various aspects of ante-partum hæmorrhage. First the clinician must be sure the bleeding is actually coming from the uterus; therefore rectal or urinary tract bleeding or hæmorrhage from the cervix or vaginal wall is excluded. This point being determined, the next step in diagnosis is to differentiate between accidental hæmorrhage and *placenta prævia*. The history of an accident or fall suggests accidental hæmorrhage. Signs of toxæmia often make this the more probable diagnosis. Also the bleeding is usually sudden and brisk at the outset and accompanied by abdominal pain. With *placenta prævia*, however, the hæmorrhage is usually painless, and tends to recur and increase. The presentation of the fœtus and relation of the presenting part to the pelvic brim should be ascertained. *Placenta prævia* prevents engagement of the presenting part and may cause a transverse lie or breech presentation. Tenderness on abdominal examination suggests accidental hæmorrhage with some retained blood. Vaginal examination may start serious bleeding and should be undertaken only in hospital, where all facilities for treatment are available. Before labour and with the cervix closed, it may not yield much information. But when some dilatation of the cervix has occurred the placenta may be felt either across the os or somewhere in the lower uterine segment. In concealed accidental hæmorrhage, sudden acute abdominal pain with shock or collapse occurs in a patient showing signs of toxæmia. The uterus feels tense and tender and may undergo gradual passive enlargement. In discussing treatment, the author states that hæmorrhage in late pregnancy is a danger sign and, however slight, should never be ignored. Early removal of the patient to hospital and immediate blood grouping are advisable. If the bleeding is slight, rest in bed with sedatives is recommended. If more severe, labour should be induced. The author recommends rupture of the membrane and plugging of the vagina. If labour has started, rupture of the membranes is still helpful in increasing the force of uterine contractions. Small doses of pituitary extract (0·25 cubic centimetre at half-hourly intervals) may be given if the hæmorrhage persists. In concealed accidental hæmorrhage, the immediate concern is the treatment of shock and replacement of blood. The membranes should not be ruptured until the uterus shows signs of regaining its tone. Should the patient show no signs of recovering from the shock, a quick Cæsarean section may give her her only chance, and, at times, it may be necessary to follow it by hysterectomy. In the treatment of *placenta prævia* Cæsarean section offers the best chance of survival for mother and baby. It should not be performed after plugging the vagina or after severe bleeding. In other cases the bleeding may be arrested by rupture of the membranes, by plugging the vagina or by bipolar version.

Toxæmia of Pregnancy.

ERIC STACEY (*The Practitioner*, January, 1945) discusses the problems of albuminuria and eclampsia. He points out that albuminuria of pregnancy does not often pass into eclampsia without going through the stages of pre-eclampsia. If it is allowed to last too long, it leads to permanent vascular and often renal damage, in addition to death of the fœtus *in utero*; thus treatment must be guided by these considerations. As regards diet, nothing has done so much good as the so-called water balance diet, in which attention is paid to a balance between the fluid intake and the urinary output. Salt, being a causative agent in water retention, is eliminated. The author believes that the deficiency states which have resulted from a diet with a low protein content are greater in number than the good results that follow a liberal protein allowance, which will prevent the body calling on its own protein to supply the necessary Calories and protein. For the first twenty-four hours an almost fluid diet is desirable, in order to establish a standard on which to judge the blood pressure and the results of chemical analysis of the blood and urine. Then the diet is gradually increased to the 2,500 Calorie level, which includes milk, fish, veal, chicken, *et cetera*. How long this treatment can go on depends largely on the response, but as no permanent cure can be established whilst pregnancy continues, the question of induction arises; if possible the patient is carried on to the last month, but in cases of pre-eclampsia or toxæmia, labour should be promptly induced and rarely delayed more than two weeks. Of the choice of methods, rupture of the membranes is the quickest (short of Cæsarean section, which should be deprecated), but is fraught with greater risk to the infant than the slower methods.

British Medical Association News.

MEETING OF THE FEDERAL COUNCIL.

A MEETING of the Federal Council of the British Medical Association in Australia was held at the Medical Society Hall, Albert Street, East Melbourne, on March 12, 13, 14 and 15, 1945, SIR HENRY NEWLAND, the President, in the chair.

Representatives.

The following representatives of the Branches were present:

New South Wales: Dr. A. J. Collins, D.S.O., M.C., and Dr. W. F. Simmons.

Queensland: Dr. A. E. Lee and Dr. T. A. Price.

South Australia: Sir Henry Newland, C.B.E., D.S.O., and Dr. R. J. Verco.

Tasmania: Dr. C. Craig and Dr. J. S. Reid.

Victoria: Dr. F. L. Davies and Dr. H. C. Colville.

Western Australia: Dr. N. M. Cuthbert and Dr. F. W. Carter.

The President welcomed Dr. A. J. Collins as a member of the Federal Council.

Minutes.

The minutes of the previous meeting of September 25, 26, 27 and 28, 1944, which had been circulated amongst members, were taken as read and signed as correct.

Appointment of Office-Bearers.

Only one nomination had been received for the office of president, that of Sir Henry Newland, who was declared elected. Two nominations had been received for the office of vice-president, those of Dr. A. J. Collins and Dr. H. C. Colville. The names were submitted to a ballot and Dr. H. C. Colville was elected. Only one nomination had been received for the office of honorary treasurer, that of Dr. W. F. Simmons, who was declared elected.

Appreciation of the Services of Dr. George Bell to the Federal Council.

Dr. H. C. Colville, in thanking the members of the Council for his election to the office of vice-president, paid a tribute to the work that had been done for the Federal Council over a period of many years by Dr. George Bell. It was resolved on the motion of Dr. Colville:

> That the Federal Council place on record a minute of appreciation of the work done by Dr. George Bell, O.B.E., since its inception in 1933, as treasurer since 1935 and as vice-president since 1939.

Death of Viscount Dawson of Penn.

The President referred to the recent death in England of the Right Honourable Viscount Dawson of Penn, President of the British Medical Association. He reminded the Council that Lord Dawson had been president during 1932, the centenary year, and that he had been elected as president for a second term in 1944 on the death of the late Beckwith Whitehouse and again in December last for the coming year. The President spoke of the value of Lord Dawson's work for medicine and for the Association and made particular reference to his activities in the House of Lords. It was resolved:

> That the Federal Council place on record its appreciation of the services rendered to the British Medical Association by the late Lord Dawson of Penn.
>
> That a letter of condolence be forwarded to Lady Dawson.
>
> That a copy of the first resolution be forwarded to the Parent Body.

Death of Major-General Rupert M. Downes.

The President referred to the death of Major-General Rupert M. Downes, which had occurred during the previous week as the result of an aeroplane accident. He said that Major-General Downes had rendered long and honourable service to the medical profession and to the people of Australia. During the war of 1914-1918 he had achieved high distinction with the Australian Army Medical Corps in the Middle East. Before the present war and during its early stages he had built an efficient Army Medical Service for the Commonwealth. As Inspector-General he had subsequently visited many theatres of war and latterly he had undertaken to act as medical historian of the Australian Army Medical Corps in the present conflict. The President had no doubt that he would have compiled a history worthy of the service. It was resolved:

> That the Federal Council place on record its appreciation of the services rendered to the nation and to the profession by the late Major-General R. M. Downes and that a letter of condolence be sent to Mrs. Downes.

Finance.

Dr. W. F. Simmons presented the financial statement and balance sheet as at December 31, 1944. The statement, which included the Federal Council account and the Australasian Medical Congress (British Medical Association) Fund account, was received and adopted.

In discussing the *per capita* payment from the Branches to the Federal Council for the current year, Dr. W. F. Simmons pointed out that the previous year had closed with a debit balance of more than £500. Had it not been for the generosity of the New South Wales Branch in advancing the money, the Federal Council would have been without funds to meet its liabilities in the first two months of the present year. He hoped that the proposed alteration in the by-law would make such an unfortunate happening impossible on any future occasion. To ensure adequate funds for the next twelve months, he thought that the *per capita* payment from the Branches should be fifteen shillings. This recommendation was accepted.

Amendment of the By-Law Dealing with Expenses.

At its previous meeting the Federal Council discussed the way in which unavoidable expenditure was to be met in connexion with meetings called because of some emergency. The Council resolved on that occasion that the General Secretary should obtain legal advice on the amendment of the by-laws to provide that the Honorary Treasurer, acting on behalf of the Federal Council, might be empowered to make additional calls on the Branches within the maximum limit provided by the present by-law dealing with expenses. The General Secretary reported that he had consulted the Council's legal adviser and that he had drafted a by-law which was sent to the Branches. The Victorian and Queensland Branches had raised certain objections to the drafted by-law and a new draft had been made. The General Secretary presented the new draft as follows:

> To meet the expenses of the Federal Council each Branch shall from time to time at the request of the Treasurer pay to the Federal Council such sum or sums as may be required for that purpose, provided that until otherwise determined by the by-laws no Branch shall be required to pay in any one year a total sum exceeding twenty-one shillings for each member of such Branch. The Treasurer of the Federal Council may determine what sum or sums not exceeding the total aforesaid are from time to time required for the purpose aforesaid provided that any such determination by the Treasurer shall be confirmed at the next following meeting of the Federal Council.

The by-law was adopted.

Federal National Health Insurance Emergency Account.

Dr. W. F. Simmons presented a statement of the Federal National Health Insurance Emergency Account. The statement was received and adopted.

Medical Officers' Relief Fund (Federal).

In presenting the report of the trustees of the Medical Officers' Relief Fund (Federal), Dr. W. F. Simmons gave a short account of the operations of the fund since its establishment in 1919. No less than £23,752 had been used in loans; the greater part of this amount had been returned. Thirty-two persons had received gifts amounting to more than £9,000, and the fund at present stood at more than £9,000. The report was received and adopted.

Decorations Received by Medical Officers of the Australian Armed Forces.

The General Secretary announced that on behalf of the President and members of the Federal Council he had offered congratulations to the following members of the Australian

armed forces who had been honoured by His Majesty the King: Air Vice-Marshal T. E. Victor Hurley, C.B., C.M.G., V.D., and Flight Lieutenant J. Grantley Shelton, M.B.E.

Dr. Charles Hill, Secretary of the British Medical Association.

The General Secretary announced that on behalf of the President and members of the Federal Council he had written to Dr. Charles Hill, offering him congratulations on his appointment as Secretary of the British Medical Association, and that Dr. Hill, in reply, had expressed his warmest thanks for the message of congratulation.

Australian Communist Party.

The General Secretary reported that he had received from the Australian Communist Party an invitation to attend a meeting in Sydney on November 23, 1944, in order to indicate the policy of the Federal Council on combined diphtheria and pertussis immunization. He had replied that on account of his visit to New Zealand on behalf of the Federal Council, he had been unable to accept the invitation.

Mr. Neilson Hancock, Lay Secretary of the Western Australian Branch.

The General Secretary reported that the President had written to Mr. Neilson Hancock, of Perth, expressing the appreciation of the Federal Council of the twenty-nine years of service given by him to the Western Australian Branch in the office of secretary. The letter had been read at a dinner held in Mr. Hancock's honour by the Western Australian Branch.

New Year Honours.

The General Secretary announced that on behalf of the President and members of the Federal Council he had written a letter of congratulation to Sir Arthur Cudmore on the honour conferred on him by His Majesty the King.

Commencement of Practice by a Japanese Graduate.

A letter was received from the Western Australian Branch in reference to the commencement of practice in Perth of a graduate of the "Medical College", Japan. This man had been interned in Queensland and released. He had practised for over twenty years in Queensland, but after his release from internment had gone to New South Wales and then to Western Australia, where in virtue of the reciprocity between Great Britain and Japan in the matter of medical registration he had been registered. The Western Australian Branch felt that the New South Wales State Medical Coordination Committee should not have permitted this practitioner to leave New South Wales. Dr. W. F. Simmons scouted the suggestion that the New South Wales State Coordination Committee had any responsibility in the matter, since no State committee had any control over medical persons who were not registered in that State. Dr. F. W. Carter pointed out that the matter had gone up to the Central Medical Coordination Committee, and the letter of the Western Australian Branch was therefore received.

The Charge against Dr. C. J. Simpson, of Bright.

The General Secretary reported the result of correspondence between himself and the Attorney-General's department in regard to the charge against Dr. C. J. Simpson, of Bright, Victoria, in respect of an alleged misleading statement in an application for motor-car tires. The matter had been discussed at previous meetings of the Federal Council. The General Secretary said that Dr. Simpson's conviction had been reversed and the fine had been remitted, and he referred the Council to a statement on the matter published in The Medical Journal of Australia of December 16, 1944.

Trading Hours of Retail Butchers' Shops.

At the previous meeting the Federal Council, at the instance of the Queensland Branch, considered a protest made by the Branch to the Registrar of the Commonwealth Court of Conciliation and Arbitration against the closing of butchers' shops in Queensland on Saturday mornings. On that occasion the General Secretary reported that he had sent a copy of the letter to the Branches, and although the Federal Council agreed with the views expressed in the Queensland Branch letter, it was felt that the question was one for State and not for Federal action.

The General Secretary reported that he had received a letter from the Queensland Branch expressing its regret and disappointment at the failure of the Federal Council to champion an essential service to the public that directly concerned its health, and to demonstrate its willingness to help any or all of the States in what was a justifiable and worthy cause. The Australasian Meat Industry Employees' Union had made an application to the Commonwealth Arbitration Court for variation of the award in order to abolish Saturday trading hours. The New South Wales Branch had made a statement before the court to the effect that the closing of butchers' shops on Saturday mornings was not in the public interest. The reasons given in the statement involved the question of refrigerators, the supply of ice and the incidence of food poisoning. The General Secretary said that the court had refused the application of the union. The correspondence was received.

Penicillin.

At the previous meeting of the Federal Council a discussion took place on the supply and distribution of penicillin, and it was resolved that it should be pointed out to the Commonwealth Department of Health that it was inequitable for medical practitioners to be held responsible for the cost of penicillin. It was also resolved that the Federal Council should ask the Federal Government to take steps to remove the existing obstacles to the supply of penicillin to the public, other than those necessary to prevent its use in unsuitable cases. The General Secretary reported that he had written to the Director-General of Health. In his reply the Director-General had pointed out that the medical practitioner was not necessarily liable for the cost of the penicillin, but that somebody had to accept liability. If the medical practitioner could arrange for the patient to pay for the penicillin as it was received or could make any other satisfactory arrangement, this would be acceptable to the department. If, however, the medical practitioner ordered the penicillin, he thereby accepted responsibility for payment, if he did not make other arrangements for ensuring that the liability was accepted by some other person. In regard to the removal of obstacles, the Director-General stated that instructions had been issued which would "very greatly relax the rather restricted conditions which were necessary while the drug was in short supply". Restrictions were necessary, not because of the scientific question, but because of the amount available. As this amount was steadily increasing, it would become possible to relax the restrictions still further.

The question of distribution to country centres had been raised in a letter from the Victorian Branch, and Dr. H. C. Colville said that there was no justification for the obstacles to the availability of the drug. It was unfortunate that the Commonwealth Government gave the impression that red tape was more important to it than human lives. In Victoria there was only one distributing centre, and difficulties were experienced, especially at night. He understood that some hospitals got over the difficulties by ordering more than was required in certain cases, in order to build up a store for future use. It was impracticable for ordinary hospital emergencies to be dealt with by the government method. The method was unique and should cease. Dr. C. Craig was in agreement with Dr. Colville. Dr. A. E. Lee referred to the life of penicillin, and said that if hospitals were to be supplied the product should be turned over at such a rate that it would not deteriorate. The President explained that supplies were always available at the Royal Adelaide Hospital. Dr. W. F. Simmons said that the problem was one of storage and potency. It was resolved:

> That a request be made to the Commonwealth Government for greater facilities in the distribution of penicillin and that it be suggested to the Government that base hospitals be used as base depots for its storage and distribution.

Australasian Medical Publishing Company, Limited.

The General Secretary referred to the decision of the Australasian Medical Publishing Company, Limited, to publish lists of the members of the several Branches of the British Medical Association in Australia. He said that the Victorian Branch had written regarding the inclusion of some distinguishing mark to show which members were or had been on active service in the present war, and made the suggestion that in view of the obvious difficulties which would arise in the preparation of these lists by the Branches, references to military or other service in the 1914-1918 or the present war should be omitted. He had referred the inquiry to the President, and it had been decided to postpone the publication of the list and to refer the inquiry to the Branches. A reply had been received from the New

South Wales Branch suggesting that no distinguishing mark should be used. After discussion it was resolved that no special indication should be given either of war service (in the war of 1914-1918 or the present war) or of rank, and that at the commencement of the list a note should be added to the effect that it was impossible to give accurate information in regard to these matters.

The General Secretary reported that he had received from the company a letter in regard to the *per capita* payment for THE MEDICAL JOURNAL OF AUSTRALIA, stating that for 1945 a rebate would be allowed to the Branches in respect of each member who at December 31, 1944, had totally relinquished civil practice for continuous full-time service in His Majesty's Forces.

The Release of Personnel from the Armed Services to Resume or to Commence Medical Studies.

At previous meetings the Federal Council had considered the release of personnel from the armed services so that they might resume or commence the study of medicine. At the previous meeting, the Council, not being satisfied with the results of representations made to the Minister for the Army, resolved that the question should be taken up again with the Minister for Defence. The General Secretary reported that under the date October 18, 1944, he had written to the Right Honourable John Curtin, Minister for Defence, as follows:

> At its meeting in Melbourne on the 25th September, 1944, the Federal Council of the British Medical Association in Australia had before it a letter from the Minister for the Army in reply to a communication from the Council relative to the release of serving personnel in order to enable them to commence or resume their medical studies. The Council submitted the following requests to the Minister for the Army:
>
> 1. That arrangements be made whereby any person who, at the time of enlistment, had completed at least the first year of the medical course be released from the armed forces after a specified period of service for the purpose of continuing his studies.
>
> 2. That consideration be given to the release, after a specified period of service with the armed forces, of any person who, at the time of his enlistment, had stated it was his intention of entering the Faculty of Medicine, and was so qualified, for the purpose of commencing his medical studies.
>
> The Minister, in reply, advised that arrangements somewhat similar to those suggested by the Council already existed, and that the army had agreed to discharge soldiers who desired to commence or resume their studies in the Faculty of Medicine and certain other Faculties, subject to certain conditions, two of which related to the rank and place of station.
>
> The reply of the Minister was considered by the Council, and it was felt that the conditions laid down for release in effect impose a penalty on the soldier who, by virtue of ability, attains rank higher than that of corporal, or who is placed at an operational station outside the mainland.
>
> It was therefore decided to make further representations, and, as the matter is one which relates to personnel in all the armed services, I was requested to place it before you as Minister for Defence.
>
> In asking for your consideration the Federal Council would respectfully point out, as it did to the Minister for the Army, that, having regard to the standards desirable in members of the profession, many of the best qualified youth of Australia were, at any rate for the present, being lost to the profession because of the fact that they had elected to serve their country. It was thought, therefore, that after a reasonable period of service an opportunity should be afforded to serving personnel, irrespective of their rank or location, to commence their studies, or, if already commenced, to resume in the Faculty of Medicine.

A letter in reply was received from the Universities Commission. This letter was dated December 15, 1944, and stated that the Secretary of the Department of Defence had forwarded the Federal Council's letter through the Department of War Organization of Industry to the Universities Commission, with the request that it would write fully to the Federal Council on the matter. The Universities Commission's letter was divided into two parts. The first dealt with the provisions for the release of members of the forces to resume interrupted courses in reserved faculties. The second dealt with the provisions for the release of persons to commence courses in the reserved faculties. In the latter section it was stated that the number to be released to commence courses would not exceed 10% of the ordinary civilian quotas. This meant that the obligation of the services to release personnel to commence university courses in 1945 would be limited in all to 160. If the number of applicants was more than this or if the qualified applicants for release to commence courses at a particular university exceeded 10% of that university's civilian quota, a selection would be made by the university. The letter further stated that under the new arrangements rank was not a bar to an application for a release either to commence or to continue a course, and that in regard to applications to continue courses, the Commission felt that it would be agreed that the new provisions more or less gave effect to the proposal of the Council for new arrangements for releases to resume courses. The General Secretary then read the latest communication on the subject, a letter dated March 1, 1945, from the secretary of the Central Medical Coordination Committee.

> You will recollect that at the meeting of the Central Committee held on the 15th February, you were authorized to communicate with your Council the decision of the Government with regard to the release of members of the forces to take up or resume university studies, and the action taken by the services to give effect to the decision.
>
> Briefly the position is that the services have issued orders notifying personnel that arrangements have been approved for the consideration of applications for release for university study. The orders state, *inter alia*:
>
> (1) That personnel who desire to commence courses may be recommended for discharge if:
> - (*a*) They enlisted before their twenty-first birthday.
> - (*b*) They have completed three years' full-time service.
> - (*c*) They are qualified to enter upopn the course.
> - (*d*) They are selected within the number prescribed for release.
>
> Other personnel with at least two years' service and who are qualified to commence university courses may apply, but their applications will be considered within the quotas of reserved civilian students and will be selected in open competition with civilian applicants.
>
> (2) Personnel who desire to resume courses in reserved faculties (medical courses come within this category) which were interrupted by enlistment, may be recommended for discharge if:
> - (*a*) They have completed one year of full-time service, and
> - (*b*) In the opinion of the Universities Commission their record as a student prior to enlistment was a reasonable one.
>
> (3) Rank or location of unit or ship will not debar any applicant from consideration for discharge.
>
> (4) Eligible personnel should submit their applications in duplicate—one copy through normal service channels and the other direct to the university at which enrolment is applied for. Care is to be exercised by the applicants that the detailed particulars required are fully given. Applications which do not contain the required information will risk rejection.
>
> (5) In view of the limited time available to check applications and to arrange the release of the recommended personnel, it has been agreed to allow the applicant himself to forward the duplicate copy referred to direct to the university at which he desires enrolment. This will allow the university authorities to preliminarily check the applicant's qualifications pending receipt of the official application. Applications received after 31st January, 1945, will not be considered for the commencement of studies in the 1945 academic year.
>
> (6) The information required from applicants who desire to commence courses is:
> - (*a*) Number, name and unit, or in the case of the Navy, name, rank, official number and ship or establishment.
> - (*b*) The university at which it is desired to commence the course.
> - (*c*) The course in which enrolment is sought.
> - (*d*) All particulars of qualifications to commence that course, including the name of the examination, the State in which the examination was taken, the year of the examination, and the school from which the applicant was a candidate. In addition, any details of the pass which the applicant can furnish should be shown.
> - (*e*) Age on enlistment.
> - (*f*) Date of enlistment for full-time service.

(7) Information required from applicants who desire to resume courses is:

(*a*) Number, name and unit, or in the case of the Navy, name, rank, official number and ship or establishment.
(*b*) The university at which enrolment is sought.
(*c*) The university attended prior to enlistment.
(*d*) The course followed and standard reached.
(*e*) The last year of university attendance.
(*f*) The date of enlistment for full-time service.

(8) All applications for discharge will be forwarded through normal service channels to the appropriate headquarters, which will take action to obtain the necessary recommendation from the Manpower Directorate and issue authority for discharge in approved cases. No movement of personnel who apply is to commence before notification of approval of discharge is given.

In the discussion that followed Dr. H. C. Colville remarked that the figure of 10% for those who wished to commence their medical studies showed no preference to those who had been on active service. Dr. W. F. Simmons said that two thousand men in the services wished to study medicine. The correspondence was received.

Contract Practice.

The Contract Practice Committee.

The Contract Practice Committee of the Federal Council was reappointed as follows: New South Wales, Dr. H. R. R. Grieve; South Australia, Dr. R. J. Verco; Victoria, Dr. C. H. Dickson; Queensland, Dr. L. P. Winterbotham; Tasmania, Dr. J. R. Robertson; Western Australia, Dr. M. K. Moss; with the President *ex officio*.

The Federal Common Form of Agreement.

The General Secretary read a letter that he had received in October, 1944, from the Federal Council of the Friendly Societies of Australia, asking whether the Federal Council of the British Medical Association in Australia was prepared to operate the Federal Common Form of Agreement as tentatively adopted in 1940, and also whether it was prepared to meet the friendly societies in conference to discuss the practicability of some extended form of medical service mutually advantageous to the medical profession and to the friendly societies. The General Secretary announced that it had been decided to meet representatives of the friendly societies in conference on the following day.

The General Secretary said that he had sent a copy of the friendly societies' letter of last October to the Branches and had received replies. The Victorian Branch pointed out that the capitation rate in Victoria had been amended, and from that point of view there was now no reason why the Federal Common Form of Agreement should not be introduced. The South Australian Branch thought that the profession in South Australia should retain the right to have fees adjusted to a unit basis. The Queensland, New South Wales and Tasmanian Branches agreed that the friendly societies should be met in conference. The Western Australian Branch sent a long letter setting out in detail alterations which, it thought, should be made in the agreement.

The question was raised whether the making of alterations in the Common Form of Agreement should be considered, seeing that it had already been accepted by the Branches. Dr. W. F. Simmons said that no new problems had arisen since 1940; the basic principles of contract practice remained the same. He thought that implementation—the fixing of the rates and so on—should be left in the hands of the contract practice committee of the Federal Council. Dr. T. A. Price pointed out that proposals for universal service had been brought forward, and that the Common Form of Agreement was a concessional agreement. If the agreement dealt with a service which was non-concessional, the rate should be doubled at once. If the service was a concessional service, then he thought that its adoption by the Branches might prejudice the medical profession in its subsequent dealings with the Government. Dr. F. W. Carter also thought that the adoption of the agreement might turn out to be a danger in subsequent dealings with governments, and with this Dr. H. C. Colville agreed. Dr. Colville disagreed with Dr. Simmons in his view that no alteration had taken place since 1940. Times had changed, and the question of a concessional service went far beyond the question of a particular fee. The whole basis of the Common Form of Agreement was a concessional service, and in his opinion all contract practice was an anachronism. He thought that the question should be asked whether contract practice was conducive to the health of the community. Many of its aspects were undesirable, and did not help communal health. The subject should be considered in its broadest possible aspects. Dr. Colville viewed with some apprehension the proposed discussion of bigger and better forms of contract service. The Federal Council should consider such a matter with the greatest possible care, for the whole matter was really in the melting pot, and wide issues were at stake. Dr. C. Craig agreed with a great deal of what Dr. Colville had said, and could not see why contract practice should be extended. Dr. A. J. Collins said that the idea that lodge practice should be altered was new to him. He was not prepared to discuss the abrogation of lodge practice. Such a question would have to be referred back to Branch councils. It was finally resolved that the Western Australian Branch's letter should be considered clause by clause. Each clause gave rise to discussion, and it was eventually resolved that the suggestions of the Western Australian Branch should be sent to the Branches for their opinions in the form of the following resolutions:

1. That a Common Form of Agreement applicable to the whole of the Commonwealth should be adopted.
2. That variations in detail should be permitted where no departure from principle is involved.
3. That the question of the concessional principle in relation to lodge practice be referred to the Branches for consideration.
4. That the income limit should be enforced with the onus on the lodge secretary and not on the doctor.
5. That in computing rates applicable to country areas, such factors as distance from capital cities and large towns should be recognized.
6. That no lodge member ineligible on account of age or for any other reason for lodge sickness benefit should be accepted on the lodge medical list except in cases of preexamination and acceptance by the doctor.
7. That a common simplified form of examination for all entrants should be adopted.
8. That the words "wholly dependent" in the Federal Model Common Form of Agreement be defined.

The Queensland Lodge Capitation Rate.

A letter was received from the Queensland Branch, stating that the Prices Commissioner had now decided to allow an increase in the Queensland lodge capitation rate in accordance with the cost of living index figure. A letter was also received from the President, stating that the attention of the Central Medical Coordination Committee had been drawn to the matter at the executive officers' conference, but that it was not included in the functions of that body.

The Friendly Societies' Lodge Capitation Rate in Victoria.

The General Secretary read a letter from the Deputy Prices Commissioner bearing the date November 11, 1944, in which approval was given to the following maximum increases on existing rates: within the Melbourne metropolitan, Ballarat, Bendigo and Geelong areas, from 20s. to 26s. *per annum*, and in other areas from 25s. to 32s. *per annum*.

Conference with Friendly Society Representatives.

At a later stage of the meeting, representatives of the Federal Council of the Friendly Societies of Australia attended and addressed the Federal Council. Mr. H. Gray suggested various alterations to the Federal Common Form of Agreement. He pointed out that in 1940 the friendly societies had accepted the proposed agreement, but he suggested that it should be brought up to date. He took the clauses *seriatim* and made various suggestions. Mr. Gray was followed by Mr. A. J. Eade, who referred to the question of war widows who were members of friendly societies. The tentative arrangement by which medical officers had accepted war widows on the lists of friendly society lodges had terminated, and according to the new agreement between the Repatriation Department and the Federal Council of the British Medical Association, war widows would be removed from friendly society lists. The friendly societies wished to suggest that it should be possible for war widows who had once been members of friendly societies to continue to receive their treatment through the societies, even though the Repatriation Department was responsible for their treatment. Mr. Eade pointed out that these women were members

of friendly societies, and that medical officers in terms of their agreement with the societies ought to attend them as friendly society members. Mr. W. H. Best then spoke on the proposal to extend friendly society contract practice. He pointed out that in a national medical service most people could be drafted into one of three categories. The first comprised those at present belonging to friendly society lodges, who were receiving medical attention under existing lodge agreements. The second group included those whose incomes ranged from £6 to £12 a week or thereabouts, and who could pay some but not all private fees. The third group comprised those who were not eligible for friendly society membership because of some disability or because of lack of means. He held that arrangements could be made by which these three groups of persons could receive their medical treatment through the friendly society lodges. For the third group the Government would have to pay, the first group would continue as they were at present, and for the second group some new arrangements with an appropriate capitation rate might be made. The Federal Council was also addressed by Mr. E. C. Mawson and Mr. J. Melson, who endorsed the remarks of his colleagues. The President thanked the friendly societies' representatives for their attendance.

It was subsequently resolved that the amendments to the Model Federal Common Form of Agreement proposed by the Federal Council of the Friendly Societies of Australia should be referred to the Branches for consideration.

In regard to the question of medical benefits for repatriation war widows and others, it was resolved that the Federal Council of the Friendly Societies of Australia should be informed that the Federal Council was of the opinion that the avenue through which the women obtained medical benefits should be left to the choice of the individual concerned.

Inadequacy of the Lodge Capitation Rate.

The General Secretary read a letter from the Western Australian Branch regarding the inadequacy of fees paid for friendly society services. It was resolved that consideration of the rates paid for attendance on friendly society lodge members should be deferred, pending the determination of the rate for medical attendance under the Federal Model Common Form of Agreement.

National Health and Medical Research Council.

The official report of the seventeenth session of the National Health and Medical Research Council of May 24 and 25, 1944, copies of which had been forwarded to members, was received.

A report by Dr. W. F. Simmons, the Federal Council's representative on the National Health and Medical Research Council, of the eighteenth session, November 21 to 24, 1944, was received.

Decline of the Birth Rate.

The General Secretary read some correspondence with the Branches on the subject of the decline of the birth rate. The South Australian Branch in its reply referred to shortages of nursing staffs, to the desirability of inspection of hospitals and to the creation of new maternity hospitals. It also suggested that the time was ripe for the establishment of a chair of obstetrics in the University of Adelaide. The New South Wales Branch stated that it had referred the matter to the Section of Obstetrics and Gynæcology. Dr. W. F. Simmons referred to the report of the Special Medical Committee appointed by the Department of Public Health, New South Wales, and published in The Medical Journal of Australia of December 30, 1944. He said that he wanted to hear the views of the Federal Council on hospitals and nursing services. Dr. C. Craig said that the main cause for concern was not maternal deaths, but the fall in the number of conceptions. Dr. W. F. Simmons referred to statements that would appear in the report of the eighteenth session of the National Health and Medical Research Council shortly to be published.

Pensions for Early Sufferers from Tuberculosis.

The General Secretary read a letter from the South Australian Branch, in which it was suggested that the Federal Council be urged to press for speedy action on the part of the Government in regard to the recommendations made at the recent conference of State Premiers and government health officers. The South Australian Branch letter had been sent to the several branches. It was resolved that a letter should be written to the Commonwealth Government, urging that immediate steps should be taken to provide adequate pensions for sufferers from tuberculosis.

The Advertising of Proprietary Medicines.

At the May, 1944, meeting of the Federal Council consideration was given by the Council to the action taken in England by the Newspaper Proprietors' Association in the control of advertisements of proprietary medicines in English newspapers. After correspondence with the chairman of the Newspaper Proprietors' Association in Australia, the General Secretary reported to the meeting of the Federal Council in September, 1944, that a code in regard to the acceptance of advertisements by Australian newspapers had been in operation since 1942. The General Secretary now reported that he had received from the President in January, 1945, a copy of a letter from the managing director of *The Advertiser*, Adelaide. The managing director, Mr. Lloyd Dumas, stated in this letter that at a meeting of the Australian Newspaper Proprietors' Association it had been suggested that a committee to control advertisements should be appointed, consisting of a representative of the British Medical Association, a representative of the Proprietary Medicines Trade Council, an analytical chemist and a representative of the Newspaper Proprietors' Association, who was to act as chairman. Mr. Dumas wished to know what the attitude of the British Medical Association would be to such a proposal. Mr. Dumas pointed out also that there had during the past ten years been a tightening up on the advertising of patent medicines and that many claims which had been accepted ten or twenty years ago were now firmly excluded from the columns of reputable Australian newspapers. This was a move in the right direction, and he thought that the appointment of a committee, as suggested, would be a further important step forward. He hoped that the Federal Council would view it in that light.

The General Secretary reported that he had sent a copy of Mr. Dumas's letter to the several Branches, and that the Western Australian, Victorian, Queensland and South Australian Branches had all expressed approval. Dr. T. A. Price remarked that he did not like the proposal, and Dr. W. F. Simmons said that the New South Wales Branch, while approving the principle, was doubtful of the competency of the committee as suggested to investigate claims of patent medicine advertisers. Dr. A. J. Collins said that a committee such as that suggested could not assess new remedies. He referred to the way in which such matters were handled in America, and he did not think that the committee would be competent to do similar work. Dr. C. Craig thought that the type of committee suggested was good. The General Secretary read a statement from the Editor of The Medical Journal of Australia in which three points were made. The first was that the control of patent medicine advertising in daily newspapers was essentially different from the control of advertisements in a medical journal. Two aspects for consideration were the selection of products for advertisement and the control of claims made by advertisers in the letterpress of the advertisement. There was no need for the selection of products for advertisement in newspapers to be as rigid as in the case of medical journals. To a certain extent the same statement was true of claims made for the virtues of advertised products. Ideally the same standard should apply to both classes of papers, but in practice this would not be possible. Newspaper proprietors therefore needed some help in the selection of products and in the control of claims by advertisers. The second point in the Editor's statement had to do with a suggestion advanced in certain quarters that newspaper proprietors, in wishing to set up a special committee to deal with advertising, wished to exploit the fact that the British Medical Association through its appointee on such a committee would give its *imprimatur* to certain products. The Editor's experience suggested that it was the proprietors of patent medicines who might do this. He knew that certain newspapers had purged their columns of undesirable advertisements in spite of the fact that the process involved them in loss of revenue. The third point was that every possible encouragement should be given to the newspaper proprietors, and that no one but medically trained persons were able to help in this matter. The President said that he thought it was harmful that noxious products should be allowed to be advertised. Dr. F. W. Carter referred to advertisements used in broadcasting and to the need for their control. The President remarked that the Federal Council had to decide first of all whether it was in favour of some control being exercised, and secondly, how the control was to be carried out. When Dr. F. L. Davies moved that the Federal Council should approve of the setting up of a committee, Dr. A. J. Collins remarked that the committee would not be acceptable in New South Wales. It was therefore resolved, on the motion of Dr. A. J. Collins, seconded by Dr. W. F. Simmons:

That the Federal Council approves of the principles of investigating the claims of patent medicine advertisers and considers that a committee should be appointed to confer with the Australian Newspaper Proprietors' Association concerning the best method of implementing this proposal.

It was also resolved that Sir Henry Newland and Dr. R. J. Verco should be appointed to the committee and that they should have power of cooption.

Insurance Companies and their Accident and Sickness Policies.

At the last meeting of the Federal Council the General Secretary read some correspondence with the Fire and Accident Underwriters' Association regarding the inadequate list of diseases for which cover was given by Australian insurance companies in accident and insurance policies. He now reported that a special committee of underwriters had been set up to revise the list of diseases, and that a conference would then take place.

The Unemployment and Sickness Benefit Act, 1944.

At the previous meeting of the Federal Council, attention was drawn to the clauses in the *Unemployment and Sickness Benefit Act*, 1944, dealing with certification and secrecy. It was thought that the provisions of the act were wrong, in that a medical practitioner summoned as a witness might be compelled to divulge information received from his patient, if it was certified to be in the public interest that he should do so. The General Secretary reported that he had written to the Director-General of Social Services in the matter, and had received a reply stating that detailed arrangements for the administration of the act had not been completed, but that the Federal Council need have no fear that the department would require any medical practitioner to disclose information which it would be contrary to the ethics of the profession for him to impart. The Director-General stated that it was somewhat difficult to envisage a set of circumstances in which a medical practitioner would be required to give information without a patient's consent. His feeling was that if a case arose in which the department had good reason to doubt that the condition of a patient was as disclosed in a medical certificate produced by him, the department would be moved to ask another medical practitioner to examine the patient. The Director-General suggested that the matter should for the time being be left in abeyance, until some experience had been obtained in the administration of the act and it was possible to learn whether the circumstances mentioned by the Federal Council would be likely to arise. The correspondence was received.

Commonwealth Employees' Compensation Act.

At the last meeting of the Federal Council it was resolved that Dr. W. F. Simmons should draw up a schedule of fees in connexion with the *Commonwealth Employees' Compensation Act*. The General Secretary reported that this schedule had been drawn up, and that it had been sent to the Branches. The schedule was then discussed. A letter from the Western Australian Branch was read. The Branch sent a series of suggested alterations. These were taken *seriatim* and noted. Dr. W. F. Simmons explained that he had drawn up the schedule by taking the various Branch schedules of fees for workers' compensation cases and the fees already allowed by the Prime Minister for work in the Emergency Medical Service and had coordinated them. Dr. A. E. Lee said that the schedule perpetuated certain anomalies. Smaller fees were paid for purely clinical work than for work which was carried out by a machine-like routine. For clinical work under this schedule it might take three and a half weeks to earn five guineas, whereas a cholecystogram, which cost about 10s., was paid for at this rate. He thought that all fees for radiological and pathological work were too high, and that clinical work was underpaid. Dr. H. C. Colville thought that Dr. Simmons should be congratulated on the schedule, and that he deserved the thanks of the Council. He moved that the schedule should be approved, and this motion was seconded by Dr. A. J. Collins. Dr. F. L. Davies asked whether the schedule applied to work by specialists, and Dr. C. Craig thought that the fees for specialists should be larger. Dr. F. W. Carter referred to radiological specialists and those who made radiological examination a part of their work in general practice. He thought that for these persons there should be two schedules. He moved by the way of amendment that the question should be deferred until the next meeting of the Federal Council, and that in the meantime the suggestions of the Western Australian Branch should be sent to the Branches for their consideration. The amendment was carried, and being put again to the meeting, was carried as the substantive motion.

The Hospitals Acts Amendment Act, 1944, of Queensland.

The General Secretary reported that he had received from the Queensland Branch a copy of the *Hospitals Acts Amendment Act*, 1944, introduced in Queensland "to provide a health service act to amend the *Hospitals Act*, 1936 to 1943, in certain particulars and for other purposes". The Queensland Branch Council also sent some comments on the measure, and a copy of a letter sent by it to the Queensland Minister for Health.

Representation of the Medical Profession on Hospital Boards.

The General Secretary read a letter from the Queensland Branch, asking the Federal Council to approach the Commonwealth Government with a view to the appointment to hospital boards of members of the medical profession, in order to promote the efficiency of hospital and health administration. Dr. A. E. Lee said that the matter was important. The Government in Queensland had taken over the whole of the responsibility of hospital care, and members of hospital boards were therefore all government nominees. He thought that at present there was a good opportunity to draw attention to the advantage of the appointment of medical men to hospital boards. He thought that there were two ways in which the problem might be approached. In the first place, the Queensland Government might have its attention drawn to the advantages of the proposal. In the second place, the Commonwealth Government might be approached with the suggestion that the interests of the Commonwealth would be protected if medical men took part in the administrative work of hospital boards. He was inclined to favour the latter method. The General Secretary said that the matter had been referred to the Branches. The Western Australian Branch had approved the Queensland suggestion. The Victorian Branch thought that it was not a matter that concerned the Commonwealth Government, and the Tasmanian Branch thought that the Commonwealth Government should be approached. The New South Wales Branch expressed the opinion that medical men should be members of hospital boards; at the present time in New South Wales medical practitioners were allowed to sit on a hospital board provided they were not members of the hospital staff. The President did not think that the matter was one for the Commonwealth Government. Dr. T. A. Price said that the only qualification for membership of a hospital board in Queensland was a complete ignorance of everything connected with medicine and hospitals. Dr. C. Craig said that medical representatives sat on hospital boards in Tasmania. Dr. T. A. Price thought that the Federal Council should approach the Commonwealth Government, which would supply Queensland hospitals with money. He thought that possibly non-medical organizations might be interested in the doctors' point of view. Dr. A. E. Lee moved that the Commonwealth Government should be approached and asked that the provision of hospital subsidy should be conditional on medical representation on hospital boards. Dr. F. L. Davies thought that it was better to wait until the attitude of the Federal Council towards the Commonwealth Government's subsidy was decided. With this Dr. A. J. Collins agreed. He thought that with the disappearance of the honorary system, the voice of the medical profession would not be heard so much, and that with the present trend it was necessary to have medical representation on hospital boards. Dr. A. E. Lee then altered his motion, and it was resolved that the Federal Council should approach the Commonwealth Government with the request that it use its influence to obtain representation of the medical profession on hospital boards in the various States, and that a similar request should be made to the Queensland Government in regard to medical representation on hospital boards in Queensland.

A Visual Hygiene Council.

The General Secretary read a letter from Dr. Darcy Williams, the honorary secretary of the Ophthalmological Society of Australia (British Medical Association). In his letter Dr. Williams stated that at the fourth annual meeting of the society held in Melbourne in October, 1944, a motion had been carried regarding the desired formation of a body to be known as the Visual Hygiene Council. The function of this body would be to represent the Ophthalmological Society of Australia, and, if approved, the Branches of the

British Medical Association in consulting with and advising other bodies, such as the Society of Illuminating Engineers, and government departments or other bodies, such as the Department of Labour and National Service, in such matters as surveys of visual defects in the population and the improvement of seeing conditions in schools, industry and public works. The council was to be composed of State and other representatives, to be appointed by the council of the Ophthalmological Society of Australia as it deemed necessary. The motion also stated that the Ophthalmological Society of Australia was to ask the Federal Council to recognize the Visual Hygiene Council. The General Secretary said that he had forwarded the letter to the Branches, and that they had all approved of the suggestion. The Federal Council resolved that approval should be given to the formation of the body in question.

Special Groups.

A Federal Orthopædic Group.

The General Secretary said that a letter had been received from the honorary secretary of the Orthopædic Group of the New South Wales Branch, asking that the Federal Council should agree to the formation of a federal orthopædic group within the Association. The letter had been referred to the Branches, and they had all approved. The Federal Council therefore resolved that a special group, to be known as the Federal Orthopædic Group, should be constituted.

The Australian Association of Physical Medicine.

The General Secretary read a letter that he had received from Dr. B. G. Wade, of Sydney, signed by himself and five other practitioners, asking for the formation of a federal group, to be known as the Australian Association of Physical Medicine. The objects of this organization were to be (*a*) to further the knowledge and to help the training of students and research practitioners in the treatment of disease by physical methods, and (*b*) to work in conjunction with associated scientific bodies in furthering research. The Federal Council approved of the formation of this body.

Medical Research in Australia.

At its last meeting the Federal Council discussed medical research in Australia, and it resolved that the interests of the public and of medical science in the Commonwealth could best be served by the creation of a medical research council. It also resolved that this view should be conveyed to the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians and the Australian universities. The General Secretary reported that a letter had been forwarded to the bodies named. From most of them replies had been received expressing approval of the suggestion. Dr. W. F. Simmons reported that at the last meeting of the National Health and Medical Research Council some discussion took place on the subject of medical research. The Council had been very much impressed by the visit of Sir Howard Florey to Australia and by the departure of Dr. C. H. Kellaway to England. One of the members of the Council proposed that the sum of £1,000 *per annum* be made available to each of the Australian universities to encourage the training of medical personnel in research. The grant would be made subject to an application by the university concerned embodying the particulars regarding the trainee and the proposed scope of his training. The Council, however, recommended to the Federal Government that through the National Health and Medical Research Council a special grant should be made to the Australian universities of £20,000 *per annum*, in order to train personnel for medical research. In the discussion which followed, the General Secretary read some statements from "Medicine in Britain" by Dr. Hugh Clegg, setting out the way in which members of the Medical Research Council in Great Britain were elected, and in which interference by the State was reduced to a minimum. The President stated that he had written a personal letter to the Minister for Health on the subject of medical research. It was then resolved that a letter should be written to the Commonwealth Minister for Health, requesting that a medical research council should be established in Australia.

Industrial Medical Officers.

A letter was received from the South Australian Branch, stating that one of the members had been approached by an industrial firm to act as part-time medical officer at its works in South Australia. It was anticipated that the position would occupy probably not more than one hour on any one day, and it was proposed to pay him one guinea per hour or any part thereof. It had been suggested that the doctor should deal with such matters as (*a*) lectures and instructions to first-aid personnel, (*b*) the giving of advice on occupational diseases and the regular examination of employees likely to be suffering from them, (*c*) the making of medical examinations for every employee who desired them. It was to be understood that beyond tendering advice, the doctor would not treat or prescribe for any illness; employees needing medical attention would be advised to consult their own medical practitioners. The South Australian Branch Council was of the opinion that there might be other such arrangements in the several States, and for purposes of uniformity it had referred the matter to the Federal Council. In the meantime the doctor in question had been advised to carry on tentatively, but at the rate of two guineas per hour or any part thereof. The fee of one guinea per hour as suggested by the firm was considered inadequate. After discussion it was resolved that the rate of payment to part-time industrial medical officers should be two guineas per hour or part thereof, and also that industrial medical officers should receive fees for all workers' compensation cases, in addition to any fees received from the company or firm in respect of industrial medical duties.

The Appointment of Quarantine Medical Officers.

A letter was received from the Victorian Branch regarding an appointment recently made at a town in Victoria by the Commonwealth Department of Health. A medical practitioner had been appointed quarantine officer, although no applications had been called for the position by advertisement. It was resolved that a letter should be written to the Commonwealth Department of Health, requesting that all vacant positions in the department be advertised in the Press.

Alien Medical Practitioners.

The General Secretary reported that he had received from the Director-General of Health at Canberra a list of alien doctors licensed as at January 1, 1945, by the Commonwealth Alien Doctors Board under the provisions of National Security (Alien Doctors) Regulations.

In the discussion that took place on a letter received from the South Australian Branch on the admission of alien practitioners to membership of the Association, it was pointed out that some alien practitioners had become naturalized, and that in virtue of this fact they were no longer aliens. It was resolved that they should be admitted to membership of the Association subject to the usual conditions governing elections.

The General Secretary also read a letter from the New South Wales Branch, asking that consideration should be given to the question of the acceptance of licensed alien practitioners as members of the Association. It was explained in the letter that the Council of the Branch had refused an application for membership from a licensed alien practitioner on the ground that he was not registered. The New South Wales Branch wished to secure uniformity of action. It was explained on behalf of the Victorian Branch that licensed alien practitioners were admitted to provisional membership of the Victorian Branch. The General Secretary pointed out that there was no provision in the constitution of the Association for the admission of provisional members. According to the by-laws, the Branches had power to elect extraordinary members, associate or complimentary. Dr. H. C. Colville said that he could not see any difficulty, and he thought it was a matter for the individual Branches. After discussion it was resolved that the Branch councils should be advised of the conditions under which licensed alien medical practitioners might be admitted as extraordinary (complimentary) members.

Publicity.

The Publicity Committee.

Dr. W. F. Simmons and Dr. A. J. Collins were appointed members of the publicity committee and were given powers of cooption.

Federal Organization Fund.

The General Secretary read a letter that had been sent to the Branches on the establishment of a Federal Organization Fund. It had been decided to establish this fund at the September, 1944, meeting of the Federal Council. The main purposes for which the fund was to be established were (*a*) the better organization of the profession throughout Australia; (*b*) to enable the Federal Council to publicize its views in regard to health services generally, and particularly at the present time in regard to the *Pharmaceutical*

Benefits Act and the Commonwealth Government's proposals for medical services. There had been a general demand by the profession that the Association should give greater publicity to its views, and many members had indicated that they would be willing to subscribe to a fund to enable this to be done. The letter went on to state that it was not clear at the present moment what sum would be required for the purpose, but that, having regard to the difficulties that lay ahead, the Federal Council felt that it was desirable that there should be available a sum of £5,000—approximately one pound per member. The method of raising the money was to be left to the discretion of the Branches.

The South Australian Branch replied that a sum of one guinea should be paid by each Branch in respect of each of its members. The Victorian Branch replied that before it could consider the matter it should be supplied with more detail. The Branch wished to know how the money was to be spent and what kind of publicity was to be obtained. It had its own organization fund, and at the present time it was not able to decide on any course of action. The Western Australian Branch thought that an appeal should be made for donations. The New South Wales, Queensland and Tasmanian Branches approved of the formation of the fund. Dr. H. C. Colville said that two courses were open, either an announcement should be made in THE MEDICAL JOURNAL OF AUSTRALIA and an appeal made for subscriptions, or else the Branches should be given a quota which they would be expected to raise. The General Secretary pointed out that the Federal Council had already decided to establish a fund, and that with the exception of Victoria all the Branches had accepted the decision. Dr. H. C. Colville asked whether it was suggested that Victoria should raise £1,400, and whether the Branch was to send circulars out to its members. The General Secretary replied that the Federal Council had no machinery for the sending out of circulars. As a matter of fact, the Federal Council had a good deal of its ordinary routine work done for it on a voluntary basis by the New South Wales Branch. It was eventually resolved that an account, to be known as "The Federal Council of the British Medical Association in Australia Organization Fund", should be opened with the Commercial Banking Company of Sydney, Limited, and that any two of the following—Dr. A. J. Collins, Dr. W. F. Simmons and Dr. J. G. Hunter—should be empowered to operate on the fund.

Federal Medical War Relief Fund.

At the last meeting of the Federal Council it was resolved that a Federal Medical War Relief Fund should be established. The matter was again discussed, and the General Secretary pointed out that the Branches had all approved of the formation of this fund, and the following resolutions were adopted:

That the Federal Medical War Relief Fund be vested in trustees appointed by the Federal Council.

That Dr. George Bell, Dr. W. F. Simmons and Dr. G. C. Willcocks be appointed trustees of the Federal Medical War Relief Fund.

That each Branch Council be requested to appoint a local committee of management consisting of three members of the medical profession.

That an account to be styled "Federal Medical War Relief Fund" be opened with the Commercial Banking Company of Sydney, Limited, and that any two of the following, namely, Dr. George Bell, Dr. W. F. Simmons and Dr. G. C. Willcocks, be authorized to operate on the account.

That the General Secretary consult with the legal advisers of the Federal Council in regard to the drawing up of a deed of appointment of trustees.

That the draft letter submitted by the General Secretary, to be sent to all members of the profession in Australia under the signature of the President, be approved as amended.

Organization of the Profession.

The General Secretary gave a short account of his visit to Queensland from January 10 to 13, 1945.

Attention was drawn to a statement in the supplement to the *British Medical Journal* of November 18, 1944, at page 114, in which it was stated that the Medical Association of South Africa wanted to have complete management of its own affairs. The Medical Association of South Africa had pointed out to the Parent Body that in its opinion the time had come for the abrogation of the agreement which had been in existence for nearly twenty years. It was thought that the South African journal suffered through not being the only official journal of the Union and of South-West Africa, and also that the agreement made the South African Association virtually a subservient Branch of the British Medical Association, a position which gave rise to legal and practical difficulties. The Medical Association of South Africa desired affiliation with the Parent Body and held that such an arrangement would imply close and loyal cooperation on the part of the South African members. The Council of the Parent Body had replied that if the majority of the members in South Africa firmly desired to abrogate the agreement preparatory to affiliation, the Association at home would unhesitatingly meet their wishes.

The General Secretary read a letter from the Queensland Branch, in which the hope was expressed that the Federal Council would reconsider the reorganization of the profession in Australia. This letter had been referred to the Branches, and most of them replied that the time was inopportune and that consideration had better be left till after the war. Dr. T. A. Price said that the subject was most important. In 1937 the views of the Branches were almost unanimous regarding the formation of an Australian Medical Association, but action had been deferred on account of Empire considerations. Australia had its own problems and its own organization was necessary. Incidents occurred in which adherence to the British Medical Association was awkward. Members transferred from England were sometimes unsuitable, and the political system made power of independent action imperative. A statement by Dr. A. E. Lee was read, in which reference was made to the consideration that the Parent Body of the Association had given to the advisability or otherwise of registering as a trades union. Dr. Price said that the Australian Branches should have this power if it was required. This would be possible with an Australian Medical Association affiliated with the British Medical Association in England, and in these circumstances the profession in Australia would be stronger. Dr. Price also referred to the existence of two journals and insisted that the desire to form an Australian Medical Association did not raise any question of disloyalty or of "cutting the painter" with the Home Country. The President pointed out that in view of the replies received from the Branches, nothing further could be done at present.

Medical Coordination Committees.

The General Secretary read a letter from the Victorian Branch, in which it was suggested that the Federal Council should consider the future of the medical coordination committees. The Victorian Branch Council did not think that any attempt should be made to abolish the system of medical coordination committees, or that the Association should withdraw its representation on the committees. It did consider, however, that the Federal Council, being in a position to obtain views from all the States, should discuss the present conditions in which the activities of the coordination committees were being directed more to rehabilitation and placement of medical officers discharged from the services than to recruitment of officers to the services. This letter had been sent to the Branches. The South Australian Branch replied that the Central and State Medical Coordination Committees should continue to exist in their present form until the war was won. The Queensland Branch held the same view. The Tasmanian Branch thought that the coordination committees should be taken over by the British Medical Association as soon as possible after the war. The New South Wales Branch thought that the coordination committees should be continued on a voluntary basis during the confused period following the war. The Western Australian Branch pointed out that the legal powers of the coordination committees were not defined, and that an effort should be made to have them defined. Dr. H. C. Colville said that the object of the Victorian Branch letter was to draw the attention of the Federal Council to the way in which conditions had altered since the coordination committees were first formed. There was a feeling in Victoria that the amount of regimentation should not be allowed to go on, at least without consideration by the Federal Council. There was no suggestion that the committees should cease to exist. The President pointed out that no determination had yet been made as to which body was to control the rehabilitation of service medical officers. The Central Medical Coordination Committee thought that on account of the experience it had gained it was best qualified to deal with that matter. He had been given to understand that a conference had recently been held at Canberra on the subject, but he did not know what had taken place. Since the coordination committees were formed, the Emergency Medical Service had been established, and he thought that

it was essential that this service should be dissociated from the Central Medical Coordination Committee and work among the services. Dr. F. W. Carter said that the Western Australian Branch was very concerned over this matter. An organization was being set up, and certain committees were being appointed. The Western Australian Branch wanted to know what powers the new civil body had. The General Secretary pointed out that the same kind of problem in regard to rehabilitation had arisen in New Zealand. Dr. A. J. Collins said that the New South Wales Branch wanted to have the coordination committees working on a voluntary basis, because their administration had been transferred from the Department of Defence to the Department of Health. He held the view that harmony was more likely to be achieved under a voluntary system than under one controlled by the Government. Dr. W. F. Simmons pointed out that the coordination committees had accumulated a great deal of information, and that this should not be lost. There was available to men information that could not be obtained from any other source. In his long association with the State Coordination Committee of New South Wales he was not aware of a single case in which a man in practice before the war had been diverted somewhere else on demobilization. After further discussion the correspondence was received.

A letter was received from the Queensland Branch, in which exception was taken to criticism of the Branch by the General Secretary in a statement published in THE MEDICAL JOURNAL OF AUSTRALIA of October 28, 1944, at page 458. The criticism had to do with the direct approach made by the Queensland Branch to the Central Medical Coordination Committee. The President pointed out that the Central Medical Coordination Committee wished to be approached directly from the Federal Council. No action was taken in regard to the Queensland Branch's complaint.

At this stage of the meeting the President left the chair, which was taken by the Vice-President, Dr. H. C. Colville. Dr. J. Newman Morris was present by invitation at this section of the meeting. The Federal Council had before it two letters from the Queensland Branch. In the first, dated January 15, 1945, the Queensland Branch forwarded a resolution of Council as follows:

> That this Council expresses its lack of confidence in the present Federal Council representatives on the Central Medical Coordination Committee.

The General Secretary said that in acknowledging this letter he had informed the Queensland Branch Council that the motion would be discussed by the Federal Council if the Branches and members of the Federal Council were furnished with some reasons why the Queensland Branch Council expressed its lack of confidence in the present representation. The General Secretary then read the reply from the Queensland Branch.

Motions moved by the Queensland representatives expressing lack of confidence in the Federal Council's representatives on the Central Medical Coordination Committee were lost. It was then resolved, on the motion of Dr. H. C. Colville, seconded by Dr. A. J. Collins:

> That this Council records its complete confidence in its representatives on the Central Medical Coordination Committee.

It was also resolved (the President occupying the chair):

> That in view of the fact that the Central Medical Coordination Committee is now under the control of the Department of Health, the Government be requested to remove the ban of secrecy imposed on members of the committee, except in special circumstances and at the discretion of the chairman.

Pharmaceutical Benefits Act, 1944.

A Press Statement by the Minister.

Discussing the *Pharmaceutical Benefits Act*, 1944, the General Secretary read the copy of a Press statement by the Minister for Health, which was published on December 13, 1944. In his statement the Minister had remarked that a proportion of doctors' prescriptions had no therapeutic value. The statement continued: "An idea of the number of worthless prescriptions being made up can be judged partly from the fact that, in most recent conferences with the B.M.A., Federal Health Department officers were able to produce literally hundreds of such prescriptions. Some members of the B.M.A. at these conferences thus admitted that the three or four flavourings present in some of these prescriptions were unnecessary and added that usually one would be sufficient." In his reply, the General Secretary had stated that at no time during the recent conference between the B.M.A. and departmental officials did the latter mention that they had seen hundreds of worthless prescriptions issued by members of the profession; still less were they produced. The General Secretary's statement continued: "It is true that one official not a medical practitioner did say he could produce a number of prescriptions which contained flavouring agents, but when asked whether he thought it should be a doctor's prerogative to order such flavouring agents if he deemed it necessary in the patient's interests to disguise the taste of the medicine, he replied, 'yes'."

Publicity.

The General Secretary referred to the difficulty which had been experienced by him in securing permission to use paper on which to print a brochure setting out the Federal Council's views on the *Pharmaceutical Benefits Act*. The correspondence that passed between the General Secretary and the government departments was published in this journal in the issue of February 3, 1945, at page 124.

The General Secretary reported that a copy of the statement, for dissemination among members of the public, which at the time of the Federal Council meeting was being printed, had been sent to the Branches. The Western Australian Branch had expressed the view that the statement was rather long, and the Victorian Branch had thought that its publication should be postponed in view of the reported proposals to amend the act. The General Secretary said that he had referred the matter to the President, and that the President had decided that the Federal Council's decision to issue the statement should stand. The order to proceed with the printing had therefore been given.

The Objections of the Medical Profession to the Act.

The General Secretary reported that a letter had been sent to the Branches, informing them of the objections of the Federal Council to the *Pharmaceutical Benefits Act*, and advising them not to cooperate with the Government in the use of the formulary and the prescribed forms. This letter was published *in extenso* in THE MEDICAL JOURNAL OF AUSTRALIA of October 28, 1944, at page 467. The Council then held a short general discussion on the attitude of the profession towards the measure, for it was pointed out that some members of the profession thought that it would be difficult to refuse to order certain preparations, such as penicillin, insulin and sulphonamides, on the prescribed forms when asked to do so by their patients. It was also pointed out that the formulary might be a satisfactory one. In the discussion Dr. F. L. Davies pointed out that the Federal Council had declared that it would not cooperate with the Government in the working of the act, however wide the formulary might be. He thought that unless the Federal Council was prepared to make a complete change of face, it must continue in the attitude it had taken up. With this statement Dr. W. F. Simmons agreed. He said that the Federal Council knew that such drugs as penicillin would be included in the formulary. It was, however, the principle which counted. Dr. H. C. Colville said that the Council should be careful of any misapprehension regarding the contents of the formulary, whatever they might be. The contents of the formulary had no bearing whatever on the attitude of the Federal Council. Any attempt to criticize it would be unwise and would weaken the Council's case. The Federal Council had stated its objections, and these still held in their entirety. There was no reason to suppose that there was any obligation on the Council to alter its attitude. The Council should try to avoid the possibility of any statement or criticism that doctors had staged a strike. If the attitude of the profession could be regarded as a strike, the doctors would lose support. The important question was how this accusation could be avoided. The only way was to make it clear that the objections of the Federal Council were not to the basic principle of the people having free medicine. The objections were to the way in which this objective was to be reached. It should be made clear that if the *Pharmaceutical Benefits Act* could be brought into line with the ideas of the Federal Council, the profession would cooperate. He thought that the Government should be approached, and that it should be told that if certain amendments were introduced, cooperation would be offered. The Federal Council should ask that this be done, and should make its attitude quite clear. After July 1, when the act was to be introduced, there would be a period in which the profession would refuse cooperation. Dr. Colville wanted to obtain the support of the public during this period. He thought that the statement that was being offered to the public was good, but it was rather long and might not be an adequate instrument. He suggested that something

shorter, something like a notice, should be drafted and displayed in doctors' waiting rooms. Dr. C. Craig supported Dr. Colville's views and said that he had ironed out many of the difficulties. The Federal Council had to consider the attitude of the men in practice, and Dr. Craig did not think that what had already been decided was sufficient. He thought that another letter should go to every member of the profession before the act came into force. He thought that Dr. Colville was the person who should draw up the letter to go to the Minister for Health. Dr. W. F. Simmons regretted that neither Dr. Colville nor Dr. Craig had been at Canberra to hear any of the discussions with the Government. He was not hopeful that any good would result from a further approach to the Government. Dr. A. J. Collins was inclined to be pessimistic, and did not think that an approach to the Government would be so simple as might be thought. Dr. Collins did not think that the formulary should be ignored. He pointed out that the Government's case became weaker as the formulary became wider, because so little extra had to be given by the Government to meet the requirements of the profession. Dr. Collins thought that the Government would go on with its proposals, with the idea that the doctors would eventually give in. Members of local medical associations had discussed the matter, and Dr. Collins had attended some of their meetings. He had found that in the difficult task of presenting the Federal Council's attitude, the one trump card was the question of freedom, and this led those who were disposed to find fault with the Federal Council's attitude to change their minds. Dr. Collins did not think that the use of a formulary was objectionable. Even when it was published, any objection to its details should not be carried too far. Dr. Collins thought that the medical profession could well police the act to obviate the danger of over-prescribing. He did not think that the Federal Council should just sit tight and do nothing. If it remained silent, it would be open to criticism. He thought that some notice similar to that suggested by Dr. Colville should be issued. Dr. A. E. Lee thought that the Federal Council must continue to try to bargain with the Government. He said that if the act was opposed because it was the early stage of an attempt at nationalization, then it could not be held that the profession did not object to the giving of free medicine. The Government had introduced the act, and if it failed the Government would say that its failure was due to the opposition of the doctors. The President said that he had been impressed by Dr. Colville's remarks. He had always insisted on the practitioner's freedom. Principles were eternal, but such things as pharmaceutical acts were ephemeral. The Council should adhere to the principle of freedom. The General Secretary pointed out that the Government's reply would be that it did not interfere with the practitioner's freedom to prescribe. It would state that though a practitioner should not go outside the formulary, there was no interference with his right to prescribe anything he wished. It was necessary to satisfy the members of the profession that the Federal Council's attitude was right. Local associations should have the Council's views put clearly before them. To this end he thought that all Branch Councils should arrange for special meetings to be held, and that these meetings should be addressed by members of the Council. After further discussion it was resolved that a further approach be made to the Commonwealth Government requesting the removal or amendment of those features of the *Pharmaceutical Benefits Act* which were objected to by the Federal Council.

It was also resolved that Dr. H. C. Colville and Dr. A. J. Collins should draft a letter for submission to the Commonwealth Government, setting out the Council's objections to the *Pharmaceutical Benefits Act*.

At a later stage of the meeting the following letter was submitted to the Council and appproved:

> The Federal Council of the British Medical Association in Australia is concerned at the position with regard to the *Pharmaceutical Benefits Act* which it is understood will come into force on 1st July, 1945.
>
> As you are aware, this Council has from the first been opposed to certain principles and features of the act which it considers will be detrimental to the best interests of the public. The main basis of this opposition is expressed in the following statement which has been authorized by Council:
>
> 1. The measure purports to provide a benefit to every member of the community, but in point of fact does not do so.
>
> Under the provisions of the act the community will be divided into two sections—(*a*) the individuals whose pharmaceutical requirements come within the limits of the official formulary and who will be entitled to the benefits of the act, and (*b*) the individuals whose pharmaceutical requirements do not come within the limits of the formulary and who will not be entitled to the benefits of the act. The Federal Council considers that this distinction between individuals, through circumstances over which they have no control, is unfair to the public and entirely unjustifiable, and is not prepared to accept the responsibility of making, for every individual patient, the decision as to whether he is to be entitled to benefits or not. The fact that such a decision must be made on therapeutic grounds must inevitably lead to an interference with the age-old right and responsibility of the doctor to prescribe for his patient exactly what he thinks fit.
>
> 2. The measure lays down distinct penalties for doctors who carry out certain procedures in prescribing for patients. These procedures are not considered by the Federal Council to be incorrect, and it is therefore unwilling that doctors should be placed in a position where they may be unjustifiably penalized.
>
> 3. Objection is also taken to the form of administration which, in the opinion of the Federal Council, should be vested in a corporate body.
>
> 4. Objection is taken to the opportunity which it presents of introducing a nationalized medical service through an act not drawn up for that purpose.
>
> The first objection is based on the fact that only those preparations contained in the official formulary will be free to the public; all other preparations ordered by a doctor for his patient must be paid for in full by the patient. It is obvious that in some instances it will be advisable for a doctor to vary or to depart from the preparations in the formulary in ordering treatment for his patient, and it is equally obvious that in such cases a situation will immediately arise in which the interests of the patient's health and his financial interests will be at variance. It is this situation which the Council is extremely anxious to avoid, and the remedy lies in supplying free to the public all medicines ordered by a doctor, whether they are contained within the formulary or not.
>
> It should be made clear that the Council has no objection to the principle of a formulary as such. Several formularies are in existence at the present time and are widely used by the medical profession, and the Council is prepared to state that, if the above-mentioned extension of benefits were granted and a formulary sufficiently comprehensive and otherwise satisfactory to the medical profession were issued by the Government, a very large proportion—possibly 90%—of doctors' prescriptions would be for formulary preparations. The financial involvement of the Government in providing the other 10% of prescriptions free would therefore not be a large one.
>
> The second objection refers to the terms of Section 22 of the act which renders it an offence for a doctor to prescribe for a patient without an examination. The Council wishes to point out that such action is sometimes necessary and justifiable, especially in the country, where long distances may make it impracticable for a doctor to prescribe other than by telephone urgently needed treatment for a patient well known to him. That such a perfectly correct and even life-saving procedure should involve the doctor in the risk of fine or imprisonment is regarded by the Council with the gravest concern.
>
> The Council wishes it to be clearly understood that it has no desire to deprive the public of the benefits of free medicine which the Government has seen fit to offer them, and it is in the desire that the benefits will be duly forthcoming under conditions of justice and fairness to both the public and the medical profession that this communication is being forwarded to you.
>
> The Council therefore earnestly requests the Government to reconsider the objectionable features of the *Pharmaceutical Benefits Act* as outlined above, and will be prepared to cooperate with the Government in any steps which may be taken to rectify them.

The Validity of the Act.

At the previous meeting of the Federal Council a discussion took place on the validity of the *Pharmaceutical Benefits Act*, 1944. This occurred as the result of a communication received from the Victorian Branch. The subject was mentioned again, and it was decided that consideration should still be deferred.

Medical Planning.

The Health Policy of the Australian Government.

The General Secretary said that a letter had been received from the Director-General of Health, advising the Federal Council that the Government did not wish to resume its previous conference with the Council.

The General Secretary reported that immediately after the last meeting of the Federal Council a conference had been held in Melbourne between the committee appointed by the Federal Council and representatives of the Government. He said that he had informed the Branch Councils of this conference and had sent them a statement issued by the conference. It was also suggested in the letter to the Branches that they should consider the implications of a fee-for-service system of controlled medical practice. The correspondence was received.

Medical Practice in New Zealand.

The General Secretary reported that he had visited New Zealand in October and November, 1944, to report on the fee-for-service system of medical practice which was being carried on in that dominion. He had been accompanied by Dr. C. H. Dickson, Medical Secretary of the Victorian Branch. The Federal Council had before it the report of the General Secretary.

The report, which was the subject of a leading article in this journal on April 7, 1945, was discussed, and in connexion with the excessive amount of money that was being spent by the New Zealand Government on the supply of "free medicine", the General Secretary brought to the notice of the Federal Council an advertisement published by the Department of Health in *The Auckland Star* of December 29, 1944. The advertisement is as follows.

> "You Can't Get Good Health out of a Bottle."
>
> Too many New Zealanders think they can. This country must just about lead the world as a nation of tonic-takers and pill addicts. The Social Security Fund spent more than £750,000 on medicines last year, supplied free to the public. That is equal to approximately 10s. a head for every man, woman and child in the country. And that does not take into account the vast sum spent by individuals on patent medicines and prescriptions not chargeable to the Social Security Fund.
>
> Medicines may serve an important purpose, but proper living is the real recipe for buoyant health.
>
> If those people who run to the medicine bottle or the pill box every time they feel off colour would practise a few of the rules of wise living, they would soon wonder what they ever saw in their expensive tonics and laxatives.
>
> If it is given a chance, nature has a wonderful power of righting things in its own way when the body goes wrong. Of course, your co-operation is needed—in the form of healthful living. Here is the basis of healthful living:
>
> Adequate nutrition from a balanced diet—begun before birth.
>
> Proper attention to personal hygiene (daily bath, fresh air at home and work, and adequate sleep).
>
> Healthful physical activity.
>
> Mental health, allowing the development of personality.
>
> These are four cardinal rules. They are simple and agreeable to follow, and they will create that glow of well-being, that cheerfulness and energy which come from buoyant health.
>
> Use medicine only when it is essential. If you want to be healthy and stay that way, give nature's method a trial. The result will probably astonish you.

The report was formally received and the Federal Council expressed its deep gratitude to Dr. J. G. Hunter for his trouble in carrying out the investigation in New Zealand and for the clarity and high quality of his report.

Maternity Services.

The General Secretary reported that a letter had been sent from the President directing the attention of the Director-General of Health to the Federal Council's policy in regard to maternity services. In his letter he referred to the statement in THE MEDICAL JOURNAL OF AUSTRALIA of November 1, 1941, and said that the Federal Council had not altered its views in regard to maternity services.

The Future of Medical Practice.

A letter was received from the Victorian Branch stating that its Council had resolved that the Federal Council should be urged to give further consideration to the resolutions of the Victorian Branch convocation, and to define its views on the method of payment and the method of contract. It also thought that the term "present doctor-patient relationship" should be defined. The Victorian Branch Council expressed the opinion that the six-point policy elaborated at the last meeting of the Federal Council met the present situation, and that any further moves should come from the Government. In the course of discussion the General Secretary referred to the Medical Contributions Fund, which was being established in New South Wales. It was resolved that further consideration should be deferred.

Expenses of Meetings held at the Government's Request.

At its previous meeting the Federal Council considered a suggestion from the Victorian Branch that an approach should be made to the Federal Government in regard to reimbursement of the Federal Council in respect of expenses of meetings held at government request. It was resolved that an approach should be made to the Government in the matter. The General Secretary reported that he had written to the Minister for Health, asking that the expenses of members of the Association attending conferences at the request of the Commonwealth Government should be met by the Government, and that the scale of expenses should be the same as that which operated in the case of members of the National Health and Medical Research Council attending meetings of that body. A reply had been received from the Minister, dated October 14, 1944. The Minister stated that he would approve of payment of the expenses of members of the British Medical Association if the Federal Council attended a meeting at the specific request of the Commonwealth Government, and if, as was the customary condition in such arrangements, no meeting of members of the Council or of any executive committee of the Council was held during the visit. The Minister added that the expenses paid would be similar to those paid to members of the National Health and Medical Research Council, and set out the rates in detail. During discussion it was pointed out that when conferences were held with the Government, the Federal Council had to withdraw from time to time to consider proposals made during the conference. It was held that this should not be regarded as an ordinary meeting of the Federal Council. It was therefore resolved that the General Secretary should be asked to communicate again with the Minister for Health, and ask (i) that when it was necessary for the Federal Council to meet for the sole purpose of considering a matter referred to it by the Commonwealth Government, the expenses of the members of the Federal Council attending the meeting should be met by the Government; and (ii) that when it was necessary for members of the Federal Council to attend a conference at government request, and a meeting of the Federal Council was held at the same time to consider other matters, the Government should pay a proportion of the expenses of those members attending the conference.

In regard to the agenda of conferences held with the Government, it was resolved:

> That it be a condition for the attendance of representatives of the British Medical Association at conferences convened by the Commonwealth Government that the Government inform the Federal Council exactly what matters are to be discussed and the details of any government proposal not later than six weeks before such conferences.

Hospital Services: The Government Policy of Subsidy.

At its last meeting the Federal Council discussed the proposal of the Commonwealth Government to pay a subsidy of six shillings a day in respect of any person admitted to a public hospital, and it resolved that no honorary medical officer should be expected to give honorary service to any patient in a public ward who was able to pay for private or intermediate treatment. The General Secretary said that he had communicated this information to the Branches and had also told them that at the conference with the representatives of the Commonwealth Government it had been made clear by a Treasury official that it was a condition of acceptance of the subsidy by the State governments that the means test should be abolished. In effect, any person who was admitted to a public bed in a public hospital would not be required to pay anything in respect of his maintenance in hospital or his medical care, irrespective of his financial status. Should he elect to go into an intermediate or private ward, the hospital authority would be entitled to assess whether he was unable to pay the charges required for his care in the intermediate or private

ward. The General Secretary said that the Western Australian Branch regarded the matter with concern, and had written a letter in which it was pointed out that the Perth Hospital was staffed by honorary officers. At a meeting of the honorary staff it had determined that if the means test was abolished, the honorary staff was prepared to treat sick poor in an honorary capacity. The Western Australian Branch Council thought that only the indigent should receive honorary treatment. It was opposed to salaried sessional service except for the indigent or in certain areas where it would appear necessary. It held that if possible uniformity of action was desirable. The New South Wales Branch had approved of the resolution, but had taken no steps to put it into effect. The New South Wales Branch was not anxious to depart from the honorary system. Such a departure would affect particularly hospitals in country areas. Dr. A. J. Collins said that opposition to the Government's proposals was gathering strength. At the New South Wales Branch convention it had been stated that medical officers were "not willing" to treat patients in public wards if they could afford to pay. He thought that medical practitioners should be asked not to treat those who could pay. Dr. Collins referred to an organization known as the Australian Voluntary Hospitals Association, which was not in favour of all of the Government's proposals. He thought that it would be a good thing if hospital boards were to join such an organization. Hospitals would then be able to speak with one voice. If this voice was the same as that of the medical profession, then the Government would have to take notice. It was not correct to say that all States had accepted the Commonwealth Government's proposals. Dr. Collins knew that in New South Wales the Minister for Health was opposed to them. The New South Wales authorities knew that the sum of six shillings a day would not go anywhere near meeting the whole cost of the hospital care of a patient. Acceptance of the Commonwealth Government's proposal would kill such a valuable organization as the New South Wales Metropolitan Hospitals Contribution Fund. Dr. Collins therefore moved:

> That the Federal Council is of the opinion that members of the medical profession should not attend in an honorary capacity in public wards of public hospitals patients who can afford to pay for private treatment.

The motion was seconded by Dr. F. W. Carter. Dr. C. Craig pointed out that in Tasmania there was no means test, and he referred to the hospital dispute in 1916. This had arisen because the doctors refused to attend in an honorary capacity patients who could afford to pay, and they had resigned from hospital staffs. Before this motion was passed, Dr. Craig thought that the Federal Council should consider whether there might not be a recurrence of the Hobart happenings. If the motion was passed, it would have to be put into practice. Dr. A. E. Lee said that the Federal Council should try to interpret the views of the profession. Many of the younger men believed that the honorary system was an anachronism, and he did not think that there was any great demand for continuation of the system. Dr. T. A. Price said that in Queensland there was practically no means test. He did not think that a means test could be introduced. The profession could not enforce it. They could tell patients that if they went into a public hospital they might be operated on by a house surgeon rather than by a senior officer. Dr. Price did not think that 10% of the younger men in Queensland would accept the motion. Dr. F. W. Carter said that he did not think there was anything more despicable than the acceptance of honorary service by persons who could well afford to pay for their treatment. They would occupy public beds and keep out of hospital those for whom the beds were really intended. Dr. W. F. Simmons agreed with Dr. Carter. He had expected to hear the views expressed by Dr. Price and Dr. Craig, for he knew that they had suffered from the effects of legislation. The New South Wales Branch Council had inquired of its members whether in the event of the Government deciding to abolish the means test they objected to attending in an honorary capacity those who could pay for treatment. The replies indicated very firmly that members did object to this. Dr. Simmons realized that the Federal Council had to pay heed to the views of Queensland and Tasmania, but at the same time it had to express its own views. Dr. F. L. Davies said that in Victoria finality had not been reached in the discussions on the matter. At a meeting of the Branch they had not gone so far as was indicated in the motion. The view had merely been expressed that members should not be called upon to attend free of charge those who could afford to pay. He realized that in the country conditions were different from those in the city, and that a great deal of surgery was done in the country. Dr. T. A. Price said that in Queensland the honorary system had outlived its usefulness. The President pointed out that Tasmania was not the only State in which difficulties in this matter had arisen in the past. He referred to the trouble that had occurred many years before in South Australia. Here the honorary staff of the Adelaide Hospital had been defeated. This would always happen. In Hobart and in Adelaide the staff had resigned, and this had been wrong. He agreed with much that Dr. Craig had said, and wondered how the views of the Federal Council might be implemented. He thought that alternative measures should be found, but that whatever was done, it would be necessary to obtain the cooperation of hospital boards. Dr. A. J. Collins said that it was necessary to visualize what would happen if the motion was passed. He said that doctors would continue to treat the indigent sick, and that if the boards insisted that other persons should be treated, they might for the time being be treated under protest. In adopting this attitude the members of the profession would be sticking to their guns. It could not be thrown up at them that they were doing something of which they did not approve, for the reply would be that anything that was done was done under protest. In reply to Dr. Price, Dr. Collins said that he knew of no hospital in Sydney where house surgeons were allowed to operate on patients. The real danger in regard to this matter would come in about fifteen years' time, when more hospitals were built. As Dr. Carter remarked, some of the public hospital patients, the indigent poor, might be crowded out. Under the New South Wales *Hospitals Act*, hospital beds were classifiable. If a man suffered from an urgent condition that required immediate hospital treatment, he would be admitted even if he was a millionaire. Later on his condition would be reviewed and a public bed might be declared by the hospital authorities to be a private bed. The reverse, of course, could happen, and a private bed be declared a public bed. Dr. Collins urged the passing of the motion. The motion was put to the meeting and carried.

Hospital Accommodation and Personnel.

At its last meeting the Federal Council, at the instance of the New South Wales Branch, considered the serious position in regard to hospital accommodation, and it resolved that the Prime Minister should be approached and that the position should be put before him. The General Secretary read the letter that had been sent to the Prime Minister. In this letter it was pointed out that the present position was the result of two factors. The first was the deficiency in bed provision and the second was the result of difficulties in regard to manpower, both nursing and domestic staff. The deficiency in beds reached a total of 16,647. This figure had been determined by the Medical Survey Committee of the Parliamentary Joint Committee on Social Security. It was pointed out that while the position was relieved to some extent by the absence of a considerable proportion of the population on active service, the fact remained that for civilian purposes there was a great shortage of beds. It was also pointed out to the Prime Minister that the manpower difficulties had been responsible for the closing of a considerable number of private hospitals, and that in this way the bed shortage had been aggravated. The letter went on to state that while the Federal Council realized the grave responsibility that rested on the Government in regard to the staffing of the projects necessary for the successful prosecution of the war, it suggested that the following two steps should be taken: (*a*) the release of a proportion of trained nursing personnel from the armed services; (*b*) the making available of a number of hospital wards on the pavilion system in each of the main States of the Commonwealth, preferably as adjuncts to existing hospitals. A reply had been received from the Prime Minister, stating that the Federal Council's representations had been noted and that consideration would be given to them.

Dr. F. W. Carter said that the position in Western Australia had become desperate. This was no exaggeration. In Perth three private hospitals had closed, and another was on the verge of closing because it could not obtain domestic help. This hospital in twelve months admitted as many as 1,200 patients, and 1,000 surgical operations were performed within its walls. Dr. Carter also gave details of the staff of the institution. He further said that there seemed to be plenty of unskilled labour in Perth. Stewardesses and barmaids seemed to be abundant, and there were more than 100 conductresses in the tramway department. Dr. Carter thought that it was time that some inquiry was made into the manpower activities in the several States. Dr. A. E. Lee asked whether any help was available from the Order

of Saint John, and Dr. A. J. Collins answered that no help had been forthcoming from that quarter. Dr. H. C. Colville supported Dr. Carter. He thought that stewardesses and barmaids did necessary work, and he held that the true cause of the shortage was that women who ought to be doing the domestic work in hospitals were in the women's services, which were so attractive to them. He did not know what motive activated the Government in enlisting these women in the services, but he presumed that there was a motive. It was a fact that essential home services had been reduced to a state of wreckage, and no attempt was made to do anything about it. He thought that the Federal Council should have the courage to say what it knew to be the chief cause. Dr. W. F. Simmons referred to a committee of the Federal House, which inquired into the number of women employed in army hospitals. He knew that this committee had not succeeded in discovering the true state of affairs. It was resolved:

> That the Federal Council bring to the notice of the Prime Minister the desperate position of the hospitals, private and public, in Australia, resulting from an acute shortage of nursing and domestic staffs, and urges that steps be immediately taken to transfer female workers from unessential civil occupations and the services.

The Medical Services in Tasmania.

Attention was drawn to a statement published in *The Mercury*, Hobart, reporting some evidence given before the Parliamentary Joint Committee on Social Security. The evidence of Mr. Tudor, Secretary of Public Health, stating that after the war they would have from 2,000 to 3,000 doctors to choose from, was noted.

Broadcast Debate on the Nationalization of Medicine.

The Federal Council formally received a copy of the broadcast debate in "The Nation's Forum of the Air" of November 15, 1944, from the Australian Broadcasting Commission.

A Statement from London on a National Health Service.

The General Secretary read a letter that he had received from the President in December, 1944, drawing attention to a statement that appeared in *The Daily Telegraph* of London on September 25, 1944. This statement was signed by six general practitioners and six consultants and specialists, and dealt with the dangers to be avoided in a State medical service. The question arose whether a letter drafted on similar lines might be sent to the newspapers in each of the Australian States. It was resolved that the time was not opportune.

Publicity.

Reference was made to the proposed brochure on medical planning that was to be issued for public circulation. It was resolved that the publication of the brochure should be deferred.

War Emergency Organization.

Conditions of Service Committee.

Dr. F. L. Davies and Dr. H. C. Colville were reappointed members of the Conditions of Service Committee.

Repatriation Commission.

At its previous meeting the Federal Council discussed the question of medical benefits for widows, orphans and widowed mothers of soldiers in the present war. It will be remembered that although the original arrangement to treat the dependants named in accordance with the terms of friendly society lodge agreements was made for three months only, more than three years had elapsed at the time of the previous meeting, and the Minister for Repatriation had persistently refused to come to an agreement on the matter. At the meeting in May, 1944, it was reported that the only point in a proposed agreement to which the Minister would not assent was the clause requiring readjustment of payment according to the basic wage index. After further procrastination on the part of the Minister, the Federal Council at its meeting in September, 1944, had before it a letter from the Minister asking the Council to agree to a continuation of the existing plan until the close of the financial year, that is, until June 30, 1945. The Council then refused the Minister's request, and sent him a telegram to that effect. In reply the Minister stated that further advice would be forwarded when a determination had been reached on reconsideration of the problem. Later a telephone communication was received from the Commissioner for Repatriation, stating that the Minister had agreed to the terms of the agreement submitted by the Federal Council, and that a written communication to that effect would be forwarded in due course. The General Secretary said that the communication in question had come to hand and had been forwarded to the Branches. He had also sent to the Branches the agreement with the amendment proposed by the Repatriation Commission. The Federal Council then considered the agreement clause by clause and agreed to certain alterations.

At several of its previous meetings the Federal Council had given consideration to the fact that medical officers of the Repatriation Department had no right of appeal against decisions of the Repatriation Commission in the matter of disciplinary action taken by the Commission. At the last meeting it was resolved that the matter should be taken up again with the Minister for Repatriation. The General Secretary read a letter from the Minister dated December 4, 1944. In this letter the Minister pointed out that the repatriation staff regulations relating to offences by members of the staff were in terms similar to the provisions of the *Commonwealth Public Service Act*, and therefore it was evident that the Repatriation Commission was in the same relative position as the Public Service Board. For example, if a member of the staff in any State were censured by the Deputy Commissioner of Repatriation in that State, the Deputy Commissioner, in accordance with the staff regulations, would notify the Commission of his action. The officer, if aggrieved by the decision, could lodge a written appeal with the Deputy Commissioner, with a request that the appeal be transmitted to the Repatriation Commission for consideration and decision. This procedure appeared to the Minister to be appropriate, and he felt that there was no need to have it amended. The Minister went on to state that should any officer still consider that he had been treated unfairly, he (the Minister) would be prepared personally to investigate the whole of the circumstances. This, of course, would apply only to a major offence, in respect of which an officer had been suspended from duty, and not to a case in which a caution or reprimand had been administered by the department following on some minor misdemeanour. The General Secretary said that a copy of the Minister's letter had been sent to the Branches. The Western Australian Branch had replied that it did not agree that the Repatriation Commission was in the same relative position as the Public Service Board, because the Repatriation Commission was the employer of the person concerned. After further discussion it was resolved that the correspondence be received.

A letter was received from the New South Wales Branch, asking that the Federal Council should give consideration to the policy of the Repatriation Department in regard to the treatment of ex-service personnel suffering from war disabilities. According to this policy the Repatriation Department required such personnel to receive attention from the local medical officer appointed by it. The Council of the New South Wales Branch thought that this would have the effect of depriving ex-service men of the attention of their own doctors. Moreover, with the large number of men to be discharged from the services with disabilities, the work entailed would probably prove to be a great burden on those medical officers appointed by the department. The New South Wales Branch Council thought that the Repatriation Department should be asked to amend its policy so that ex-service men might receive treatment from their own medical attendants. The New South Wales Branch letter had been sent to the Branches, and the Victorian, South Australian and Queensland Branches had not approved of the New South Wales suggestion. It was pointed out by Dr. J. C. Verco that the ex-soldier's private medical attendant might not be *au fait* with military procedure, and this was an important consideration. After further discussion the correspondence was received.

The Rehabilitation of Medical Officers in the Armed Services.

Further consideration was given by the Federal Council to the rehabilitation of medical officers in the armed services. At the last meeting of the Federal Council particular reference was made to the opportunities for post-graduate work which should be given to medical officers whose units were staging, and also to the provision by rotation of hospital appointments for medical officers, and it was resolved that the representatives of the Federal Council on the Central Medical Coordination Committee should bring these questions before the notice of the services directors. The

General Secretary read a letter from the Secretary of the Central Medical Coordination Committee, in which it was stated that when facilities were available and opportunities offered, every effort was made by the services to give medical officers experience and teaching to enable them to maintain their professional standards. It was also stated that in regard to the period of hospital residency granted to young graduates before their enlistment in the forces, the policy of the services medical directors was that each medical student on graduation should have a minimum of nine months as a resident medical officer in a civilian hospital before being called up for full-time duty in the services. In isolated cases, when this civilian hospital training had not been received, the policy was for such officers to have a period of twelve months' residence in military hospitals, this being regarded as equivalent to the required civilian hospital training. Dr. A. E. Lee reported that a request had been made by the Deputy Director of Medical Services in Queensland to prepare fortnightly courses for service personnel. To one of these courses twelve officers came. They came as it were under false pretences, because the course was not declared to be an official school. No transport was provided for these men, and the impression was conveyed that the army was very lukewarm about the matter. The twelve men concerned were like a lost battalion. They were all men who had seen whole-time war service, and during that period had done no clinical work at all. There were many more like them, who urgently required clinical training. There was a tendency to lose sight of the senior men who had been compelled to spend the whole of their war service in administrative positions. The plight of these men was tragic. Dr. T. A. Price said that long periods of post-graduate study were not likely to be provided. Any post-graduate work would have to be fitted in during military service. Dr. W. F. Simmons said that post-graduate training would be given through the Department of Post-War Reconstruction. He referred to the smallness of the financial allowance that was made for officers during this period. The President remarked that the Central Medical Coordination Committee had protested against the smallness of the financial allowance. After further discussion it was resolved that the representatives of the Federal Council on the Central Medical Coordination Committee should be asked to make further representations to the committee on the matter.

Reference was made to the provision of assistantships and partnerships for demobilized medical officers. The General Secretary read a letter from the secretary of the Central Medical Coordination Committee, stating that the committee had given consideration to the need for the provision of assistantships and partnerships for demobilized medical officers as a practical means of rehabilitation. The letter went on to state that until it was known what medical officers could be released, no definite approach regarding the placement of individuals was practicable. At the same time, it was thought that no harm could be done if the members of the Branches of the British Medical Association were urged to make liberal offers for partnership and assistantship appointments to those who had served in the fighting forces. The suggestion was made that the Federal Council should urge that any offers from medical practitioners in this respect should be on the most generous terms possible. The correspondence was received.

An inquiry was received from the Central Medical Coordination Committee regarding the resources of the Branches of the British Medical Association in regard to rehabilitation, particularly on the financial side. The General Secretary said that a reply had been sent, stating that the available resources would depend largely on the status of medical practice at the conclusion of hostilities. The correspondence was noted.

A communication was received from the Queensland Branch, conveying the suggestion of a member. This member pointed out that when the courses of medical studies in the Australian universities were shortened, the periods spent by graduates in resident appointments at hospitals were also shortened. Before very long the courses of study at universities would be restored to the original length. This would mean that a lag period would take place, in which resident medical officerships of a longer period than usual would be available. The suggestion was that this lag period should be used as a time for the training of medical officers from the services. It was thought that in this way at least 200 officers would have an opportunity of six or seven months' rehabilitation under the best conditions of hospital practice. Dr. A. E. Lee suggested that the President should put this idea to the Central Medical Coordination Committee. Dr. A. J. Collins pointed out that the universities had commenced to lengthen their courses again. In Sydney in the coming year there would be no fourth year students. There the lag period would come earlier than expected. After further discussion it was resolved that the representatives of the Federal Council on the Central Medical Coordination Committee should place the suggestion of the Queensland Branch before that committee.

Medical Attendance on Members of the Military Forces by Civilian Practitioners and the Payment of Mileage.

At previous meetings of the Federal Council consideration was given to the payment of mileage or of a travelling allowance to civilian practitioners who were called on to attend members of the military forces at a distance. The General Secretary reported that an increase in allowance had been made, and that the correspondence on the matter had been published in THE MEDICAL JOURNAL OF AUSTRALIA of December 16, 1944.

Shortage of Motor-Cars.

Further reference was made to the shortage of motor-cars for medical practitioners. The General Secretary read a letter that he had received from the secretary of the Central Medical Coordination Committee, in which it was stated that at a conference of executive officers of State medical coordination committees a proposal had been made that there should be established a pool of motor-cars, so that one might be available to a practitioner when his car was being serviced or overhauled. The secretary of the Coordination Committee asked whether the State Branches of the Association would be prepared to manage such a pool if motor-cars were available for the purpose. The General Secretary said that the Queensland Branch had replied that it was prepared to manage such a pool, but the other Branches wanted more information on the subject. It was pointed out that the Queensland Branch through its medical agency had a motor-car available for use by Branch members when their own cars were being repaired. A letter was also read from the Director of Road Transport, in which it was suggested that every medical practitioner with more than one motor-car should make additional cars available to practitioners requiring them. This suggestion had been put to the Branches and had not met with approval. The General Secretary said that the South Australian Branch had replied that the suggestion was not practicable, and when he had inquired why, he had been told that the South Australian Branch sent out a *questionnaire* before its reply was forwarded. The kind of thing which was reported was that motor-cars had travelled many thousands of miles and in normal times would have been replaced. The result was that continual servicing was required, and a man who owned two motor-cars found that one had to be serviced while the other was in use. In other words, it was impossible to conduct a practice under present conditions without two motor-cars. The General Secretary said that in New South Wales the position was acute. Many motor-cars belonging to doctors had travelled over 100,000 miles. Some reconditioned "Plymouth" motor-cars had been made available by the department after they had been driven by American service personnel for 25,000 to 30,000 miles. For these cars the department asked no less than £575. The obvious solution was that low-priority motor-cars should be taken over by the Government. After further discussion it was resolved that the Director of Road Transport should be advised that the Federal Council, after having made inquiries from members of the profession throughout Australia, was of the opinion that it was impossible for the profession to release any motor-cars, and that on the contrary the position within the profession was urgent, and that the Federal Council recommended that the position should be relieved by the calling up of motor-cars of low priority.

Rationing.

A communication was received from the New South Wales Branch, forwarding a letter from the Section of Gynæcology and Obstetrics. Attention was drawn to the difficulty of obtaining sufficient proteins for expectant and nursing mothers, especially in view of the egg rationing. The letter had been sent to Dr. W. F. Simmons, the Federal Council representative on the National Health and Medical Research Council. He had replied that the question had been before the Nutrition Committee of the last-mentioned body, and that a warning had been issued by it in regard to the probable egg shortage during 1945. It had been recommended that eggs should be preserved in cold storage against this event. Unfortunately sufficient notice had not been taken

of this warning. Dr. Simmons said that at the time of the meeting there was no milk rationing in Sydney, and that the position in regard to fish was better.

A letter was also read from the Victorian Branch, stating that there was considerable astonishment amongst Victorian practitioners at the omission of sufferers from tuberculosis and diabetes from the list of those entitled to receive priority under the egg allowance scheme. The Victorian Branch thought that the Federal Council might make some representation in the matter to the authorities. The General Secretary said that the Victorian Branch's letter had been sent to the other Branches. The South Australian Branch had replied that tuberculosis patients certainly should be included in the egg allowances scheme. The Queensland Branch expressed astonishment that patients with chronic dyspepsia had been included while those with tuberculosis had not. The New South Wales Branch protested against the omission of diabetics and tuberculosis patients, and stated that the Anti-Tuberculosis Association had made representations to it in the matter. Dr. W. F. Simmons spoke in defence of the Special Diets Committee of the National Health and Medical Research Council. He said that the committee had been informed that after March 1 no eggs at all would be available for invalids, and that they would be supplied only to nursing and expectant mothers and to children up to five years of age. The committee had been asked what groups should have eggs after these persons had been supplied. The committee had said that patients with ulcer or throat conditions should come next. Then someone had "put over a swift one" in regard to chronic dyspepsia. What the committee really had in mind was persons over seventy years of age, and he added that the committee was thoroughly ashamed that chronic dyspepsia should be included amongst the conditions. When it became apparent a few weeks earlier that there would be no real shortage of eggs, it was clear that all tuberculosis patients would be able to secure them. Diabetics, however, were not in the same priority group as patients suffering from tuberculosis, for they did obtain extra butter and meat. Dr. A. J. Collins said that he supposed that the chronic dyspepsia group would be removed. He did not think that all ulcer patients needed twelve eggs a week. He thought that seven would be enough, and that diabetics might also have seven. He recognized that the problem was difficult and thought that the profession could have confidence in the committee. It was resolved that the matter should be left in the hands of Dr. W. F. Simmons.

Income Tax Deductions and Amounts Paid to War Benefit Funds.

At the previous meeting of the Federal Council reference was made to a decision of the income tax commissioner regarding amounts contributed by medical officers to war benefit funds. The commissioner ruled that when practitioners were employees, the amounts of their contributions could not be allowed as income tax deductions. It was decided that an approach should be made to the Federal Treasurer, to secure an amendment of the act, and at the last meeting of the Federal Council a reply from the Minister to the effect that he could not accede to the request had been read. The General Secretary now reported that he had received a letter from Dr. H. M. Birch, of the Mental Hospital, Parkside, Adelaide. Dr. Birch pointed out that the Minister had stated in effect that Dr. Birch's income had not been increased by reason of the fact that fellow practitioners were on service, and that he was therefore not entitled to any consideration for moneys paid by him into the scheme. Dr. Birch pointed out that this was not correct, for in addition to his salary he received fees as a member of army psychological boards and for work done for the Repatriation Commission. He realized that the amount involved was not great, but he did not think that the Minister's reasoning should be allowed to pass unchallenged. It was resolved that a further approach should be made to the Treasurer in the matter.

The Australian Council for UNRRA.

The General Secretary said that Dr. A. J. Collins had been compelled to resign his position as Federal Council representative on the Australian Council for UNRRA, owing to pressure of work, and that it was necessary to appoint someone in his place. Dr. A. J. Collins suggested that Dr. William Wood, of Sydney, should be invited to fill the position. Dr. Collins pointed out that the Australian Council for UNRRA had been formed to prepare the way for the central UNRRA association to visit Australia. They had been told that the objective of UNRRA was to care for the dispossessed people of Europe. These were to be the first priority. Millions of people were destitute as a result of enemy action, and many of them would need to be transported back to their homes or where their homes had formerly been. Again, many persons would have to be rehabilitated in countries vacated by the enemy. These people would have to be fed, clothed and educated. Therefore teachers, psychologists, doctors, dentists and artisans would have to be provided. There was a shortage of medical men in such countries as Czecho-Slovakia, where many doctors had been executed. The same was true of Holland and Belgium. This raised a great problem. In Australia attempts were being made to assess the medical requirements of the Commonwealth and to restrict the number of medical students to meet those requirements. Dr. Collins wondered whether this was right, in view of the world need. He thought that it was just as wrong to limit the production of doctors as it was to limit the production of wheat. It would be desirable to have a survey of the world requirements of doctors. There was no doubt that Australia had certain responsibilities in this regard. The central council of UNRRA had little idea of the type of doctor that was required. When a question bearing on this had been asked of the council, the reply was that they did not know, but that as many doctors as possible should be obtained. He thought that some units would be sent to serve in the Balkans, and that the Australian Red Cross Society would finance them. He understood that while there was not a great deal to be done at present, much more would be expected later on, especially in the Far East. When the time came, he thought that Sydney would be the centre of Australian UNRRA activities, and that both doctors and anthropologists would be needed. Dr. Collins's motion for the appointment of Dr. William Wood was seconded by Dr. Simmons and carried.

On the motion of Dr. W. F. Simmons, the Federal Council resolved to place on record its appreciation of the services rendered by Dr. A. J. Collins on the Australian Council for UNRRA.

The Supply of Rice for Civilians.

The General Secretary referred to the communications received from the Department of Commerce and Agriculture in regard to supplies of rice for civilians. In the first place a letter, dated October 17, had been received, stating that the supply of rice upon the production of a medical certificate would be discontinued after October 31, 1944, on the ground that whole rice was not an essential item of diet for any form of sickness to which the white race was subject. Later on a second letter from the department, dated October 31, 1944, stated that the matter had been given further consideration, and that supplies of rice on the production of a medical certificate would be continued. This Gilbertian correspondence was noted.

Shortage of Ophthalmic Practitioners.

A communication was received from the Ophthalmological Society of Australia (British Medical Association), in which it was stated that at its annual meeting in October, 1944, the society had resolved that, owing to the serious shortage of ophthalmic practitioners, an appproach should be made through the Federal Council to the medical services directors, asking that the services should be combed for men willing to undertake ophthalmology as a speciality, and that the matter be treated as one of urgency. The Ophthalmological Society's letter had been sent to the Branches. The General Secretary said that the Tasmanian, Western Australian, Victorian and South Australian Branches supported the proposal. The Queensland Branch agreed that the position was acute and that any action would be appreciated. It stated that there were ophthalmologists in the army who were not doing ophthalmological work. The New South Wales Branch considered that the search for men willing to train as ophthalmologists should be made not only in the armed services but also in the civilian services. It was resolved that the directors of the medical services of the armed forces should be informed of the acute shortage of ophthalmic practitioners for the treatment of civilians, and that it should be suggested to them that medical officers in the services who were willing to be trained as ophthalmologists should be released for that purpose. It was also resolved that the attention of the services directors should be drawn to the advisability of employing as ophthalmologists medical officers who were specially trained in ophthalmology, but who were otherwise employed in the services.

The Sale and Purchase of Medical Practices.

A letter was received from the secretary of the Central Medical Coordination Committee regarding approval given

by it to the issuing of a circular letter by the State Medical Coordination Committee in Tasmania on the subject of the sale and purchase of private medical practices. In the Tasmanian letter it was stated that certain difficulties existed in regard to the sale and purchase of medical practices at the present time. The medical coordination committees had no authority to approve or to forbid such transactions, but they had the authority to direct the intending purchaser, if he was enrolled in the Emergency Medical Service, either to continue in his present practice or to conduct a practice for the civilian community of some other place within the Commonwealth. The medical coordination committees had no intention of interfering unnecessarily with private transactions between doctors, but they were entrusted with the duty of seeing that the available medical men were distributed to the best possible advantage. They could give no assurance that an intending purchaser would be permitted to carry on any particular practice. A copy of the Tasmanian committee's letter had been sent to the other State medical coordination committees, with the suggestion that they might consider the issuing of a letter in similar terms.

Shortage of Medical Equipment.

A letter was received from the Queensland Branch, requesting action in regard to the shortage of medical equipment. A letter had been sent to the Branches, to the members of the Federal Council and to the chairman of the Medical Equipment Control Committee. It was pointed out that the Medical Equipment Control Committee was responsible for the availability of equipment, and that efforts were always made to meet the needs of practitioners. It was resolved that Sir Alan Newton be informed that the Federal Council had complete confidence in the Medical Equipment Control Committee. It was also resolved that the Editor of THE MEDICAL JOURNAL OF AUSTRALIA should be invited to publish a statement advising members of the profession who were in need of medical equipment and who were in doubt as to whether it could be obtained, to write directly to the Medical Equipment Control Committee for information.

Matters Deferred.

Consideration of the following matters was deferred: the Federal Emergency Compensation Fund, public medical services, and the principles of medical ethics.

Date and Place of Next Meeting.

The date and place of the next meeting were left in the hands of the President.

Votes of Thanks.

Votes of thanks were passed to the Victorian Branch Council and to Dr. F. L. Davies and Dr. H. C. Colville for their hospitality, and to the Victorian Branch for the use of its offices.

The thanks of the Council were also extended to the President, Sir Henry Newland, for presiding.

The Royal Australasian College of Physicians.

SEVENTH ANNUAL MEETING.

THE seventh annual meeting of the Royal Australasian College of Physicians will be held at Melbourne on Friday and Saturday, May 11 and 12, 1945. The programme will be as follows:

Friday, May 11, 1945.

10.15 a.m.—Council meeting in the council room of the Royal Australasian College of Surgeons. The admission of new members will take place at this meeting.

2.15 p.m.—Scientific session in the lecture hall of the Royal Australasian College of Surgeons. "Effect of Thiouracil and Related Compounds in Thyreotoxicosis", Dr. Ivan Maxwell and Dr. Harold Ritchie. "Some Aspects of Calcium and Chloride Metabolism with Special Reference to Miliaria Rubra", Surgeon Lieutenant-Commander S. A. Sewell, R.A.N.R.

8.15 p.m.—The Third Annie B. Cunning Lecture on Nutrition. "Soils, Food and Life", by Colonel Sir Stanton Hicks, Kt., M.D., M.Sc., Ph.D., F.I.C., F.C.S., in the Public Lecture Theatre, Arts Building, University of Melbourne.

Saturday, May 12, 1945.

10 a.m.—Scientific session in the Lecture Theatre, New Royal Melbourne Hospital. Demonstration of clinical cases by: (1) Dr. W. S. Newton—a case of pulmonary tuberculosis illustrating the collaboration between physician and surgeon. (2) Dr. John Horan—a case of hypoglycæmia illustrating diagnosis and treatment. (3) Dr. S. O. Cowen and Dr. R. J. Wright-Smith—clinico-pathological demonstration on some aspects of rheumatic fever.

2.15 p.m.—Continuation of council meeting in the council room of the Royal Australasian College of Surgeons.

Correspondence.

INJURIES BY UNKNOWN AGENTS TO BATHERS IN NORTH QUEENSLAND.

SIR: With regard to the letter in your issue of March 31 last from Mr. F. A. McNeill and Miss Elizabeth C. Pope, I feel very diffident indeed in challenging such an authority on invertebrate biology as the former, who asserts the non-existence of the *Physalia* within the waters of the Great Barrier Reef. As recently as last August, I collected at least two dried specimens left high up on the beach, probably by a spring tide many months earlier. Both Mr. and Mrs. A. B. Cummings, who have spent much time on Green Island, report frequently having seen the unmistakable blue bladder of the "Blue Bottle", with its long tentacles, around the island. However, when next summer arrives, specimens will be forwarded to Mr. F. A. McNeill for verification.

It appears then that about five jelly fish at least are responsible for severe injuries to bathers, namely:

(*a*) ***Physalia pelagica***, producing lash-like weals and local symptoms mainly.

(*b*) Another unknown organism producing similar symptoms, even fatal—perhaps the same as (*a*), but according to Mr. McNeill different.

(*c*) Medusa in School of Tropical Medicine, Sydney, responsible for death of boy at Darwin.

(*d*) A carybdeid medusa.

(*e*) Unknown organism producing insignificant or unimportant local symptoms, but severe general symptoms so commonly met with in North Queensland waters.

An effort to secure specimens of the offending organisms during the next summer season has already been contemplated. Meanwhile the assistance of Mr. McNeill and Miss Pope is much appreciated.

Yours, etc.,

H. FLECKER.

52, Abbott Street,
Cairns,
April 4, 1945.

MEDICINE IN THE U.S.S.R.

SIR: I have recently received from America the first six copies of *The American Review of Soviet Medicine*. These journals are published by the American-Soviet Medical Society, and are the only publications in the English language that throw any light on the achievements of Russian medicine. The society functions under the distinguished presidency of Walter Cannon, and the journal is edited by Henry Sigerist, of international repute as a medical historian and the Professor of the History of Medicine at the Johns Hopkins University, and to whose courtesy I am indebted for the receipt of these journals.

The purpose of this letter is to inform the profession that such a journal exists and is readily accessible to any member interested in the functioning of socialized medicine. I further propose to comment briefly on the content of the first six journals.

The majority of the articles are concerned with the developments of war surgery, as one would expect. Noted Soviet surgeons such as Lebedenko, Smirnov, Burdenko and Vishnevski have contributed articles dealing with general and special aspects of the treatment and rehabilitation of war casualties. As Soviet army surgery and general organization won the warm approval and praise of the British Medical Mission that inspected the Red Army's medical services, we are safe in assuming that these descriptions are a factual account of the techniques adopted. One is impressed by two tendencies in these articles. Firstly,

there is a trend to greater specialization than is usual in British or American surgery. For example, in the larger units there are special "femur-teams" to handle gunshot fractures of the femur, and there are special teams for maxillo-facial wounds *et cetera*. The second tendency is a noticeable attempt to standardize technique, and this will probably be hailed gleefully by the Russophobes as an example of the bureaucratic strait-jacket on scientific freedom. It is clearly, however, nothing of the sort, but rather the result of painstaking research into methods of treatment, the final results of which are offered to the army surgeons as the methods most likely to produce the best results. In general it may be stated that the articles on war injury showed a comprehensive and adequate approach to the subject, but that no new ground was broken. Soviet war surgery appears to be pretty well comparable with British and American surgery, except that the Red Army casualty seems to get the attention of doctor and nurse a bit quicker and if possible before evacuation.

I was much more interested in the articles on general medical and scientific topics. One article describes a complement fixation test for the early diagnosis of typhus fever and contrasts it with the Weil-Felix reaction. The new test appears to be much preferable to the Weil-Felix in that it is positive on the first or second day of the disease, whereas the Weil-Felix reaction does not appear until the seventh or eighth day. There is an account of the splendid work done by Smorodintsev on the epidemic encephalitis of northern Russia and Siberia. In a two years campaign, during which one of his assistants died from the disease and another was left with a residual paresis, he nailed the cause down to a tick-borne virus, and evolved an immunizing vaccine which has controlled a hitherto incurable disease.

Mention must also be made of the provocative work of Bogomolets on the protective function of the connective tissue system, resulting in the elaboration by him of his anti-reticular cytotoxic serum. The possibilities conjured up by this work are exciting to say the least. Sigerist adds a footnote about this great experimental pathologist. He states that his Institute of Experimental Biology and Pathology in Kiev was one of the most modern and best equipped scientific research institutions in the world. Unfortunately the representatives of *"Kultur"* have since visited Kiev and the institute has been razed. It will be rebuilt. Finally I might mention Lina Stern's article on the treatment of established tetanus. This disease has in the past been fatal in the majority of cases. During her work on the barrier between the blood stream and the cerebro-spinal fluid, she developed a method of treating tetanus by direct injection of antitoxin into the *cisterna magna*. If injected with certain precautions and with the correct pressure, the serum makes its way directly into the ventricles, and this is claimed to be curative of established tetanus. She produces very strong clinical and experimental evidence of the truth of her claim.

It would be salutary for many members of our profession to read these journals, especially those who hug to their bosoms the delusion that bureaucracy stifles all scientific freedom and initiative. I believe that we can expect a steady and rapidly increasing flow of scientific discoveries from socialist Russia. I do not see how it could be otherwise. Should any members of the profession wish to subscribe to this journal, they should communicate with Dr. Robert Leslie, 130, West 46 Street, New York 19, New York. The subscription rate is seven dollars yearly for overseas subscribers.

Yours, etc.,

LANCE HEWITT.

Cambridge Street,
Enmore,
New South Wales.
April 7, 1945.

THE PHARMACEUTICAL BENEFITS ACT, 1944.

SIR: I would like to point out to Dr. Jaede, in reply to his letter of March 23, that the objections of the Council of the New South Wales Branch of the British Medical Association to the *Pharmaceutical Benefits Act* do not aim at depriving the public of a benefit which the Government of the day sees fit to give it. On the contrary, they aim at bringing about an amendment in the act whereby the public will obtain a better service.

The Council's chief objections to the act as it now stands, and they are also those of the Federal Council and of the Councils of all other Branches, have already been publicized, but it is well that they be reiterated.

Briefly they are:

1. The measure purports to provide a benefit to every member of the community, but in point of fact does not do so. Under the provisions of the act the community will be divided into two sections:
   (a) The individuals whose pharmaceutical requirements come within the limits of the official formulary and who will be entitled to the benefits of the act, and
   (b) the individuals whose pharmaceutical requirements do not come within the limits of the formulary and who will not be entitled to the benefits of the act.

   The Federal Council considers that this discrimination between individuals through circumstances over which they have no control is unfair to the public and entirely unjustifiable, and it is not prepared to accept the responsibility of making, for every individual patient, the decision as to whether he is to be entitled to benefits or not. The fact that such decision must be made on therapeutic grounds must inevitably lead to an interference with the age-old right and responsibility of the doctor to prescribe for his patient exactly what he thinks fit.

2. The measure lays down drastic penalties for doctors who carry out certain procedures in prescribing for patients. These procedures are not considered by the Federal Council to be incorrect, and it is therefore unwilling that doctors should be placed in a position where they are unjustifiably penalized.

3. Objection is also taken to the form of administration which, in the opinion of the Federal Council, should be vested in a corporate body.

4. Further objection is taken to the act because of the opportunity which it presents of introducing a nationalized medical service through an act not drawn up for that purpose.

If there is any section of the community competent to express an opinion on the *Pharmaceutical Benefits Act*, it is the medical profession, and I strongly contend that it has a duty and a right to point out to the Government any instance where it is in error, and anywhere it will not be serving the public interest by its endeavours, ill-conceived though well intentioned.

To assail the loyalty of the profession because it is critical of the Government's decision and because of the stand which the Government, through its refusal to accept advice, has forced the profession to take, is tantamount to depriving it of a right and a duty which has freely existed in this country. One could expect such a deprivation of rights only in a totalitarian State.

Dr. Jaede attempts to draw a similarity between the benefits under friendly society contract practice and those to be granted under the *Pharmaceutical Benefits Act*. It is fully appreciated that a full 100% benefit is not available to the lodge member; the service is not a complete service, and has never made any pretentions to be otherwise, and the lodge member knows this. The medical officer can, however, prescribe any combination of drugs in the British Pharmacopœia without cost to the patient. He will not be able to do this under the *Pharmaceutical Benefits Act*. For Dr. Jaede's information, I have the assurance of both the President of the Federal Council of the Friendly Societies' Association of Australia and the Honorary Secretary of the Friendly Societies' Association of New South Wales, that their organizations do not wish any medical officer to do other than prescribe what he thinks best in the interests of his patients without particular regard to the Friendly Society Dispensary Formulary.

There is, however, a great difference between the principles underlying the provision of friendly society benefits and those of the act. The friendly societies movement is fundamentally nothing more than a group of private individuals organized to provide themselves with certain benefits. If they so wish, they can take the necessary action to improve these benefits. On the other hand the benefits under the act are given by statute enacted by the government of the day. The determination of whether the patient will receive his medicine free of charge or will have to pay for it will not in reality be made by the Government, but by the medical profession, that small section of the community whose loyalty Dr. Jaede has seen fit to question. If such a responsibility is thrown on to the profession, then surely it is justified in raising its voice in protest, and in taking action which, it is hoped, will result in a change in the Government's policy.

Finally, in order that Dr. Jaede and any others who might think as he does will not misunderstand the position, I must

reiterate and emphasize that the Federal Council and the Council of the New South Wales Branch do not object, nor have they ever objected, to the principle of the public receiving free pharmaceutical benefits. Their objections are confined to those enumerated in the early part of this letter. At the same time it has been intimated to the Government that there are many other medical and hospital problems deserving of more urgent attention than the provision of pharmaceutical benefits, and I would sincerely like to see Dr. Jaede's pen used in support of these more deserving causes. On the other hand Dr. Jaede may care to spend his efforts in the very deserving cause of improving the wages of workers, or the payment to pensioners, so that they may obtain the better amenities of life. If at any time Dr. Jaede sees fit to act in this manner and to protest against their present inadequacy, it is to be hoped that, as they are the result of government enactments, he will not be accused of lack of loyalty by those who think differently from him.

Yours, etc.,

E. A. TIVEY.

718, Military Road,
Mosman,
New South Wales.
April 11, 1945.

SIR: Dr. Jaede, in his letter of March 23, 1945, does not, I think, make a fair contrast between prescribing for friendly society patients and prescribing under the *Pharmaceutical Benefits Act*. The general experience in the Illawarra Suburbs area is that the patient is charged only for proprietary articles and other specified drugs.

Contrast this with the practice which will obtain under the *Pharmaceutical Benefits Act*, where only a very limited number of drugs can be added to prescriptions listed in the formulary, and then only one of such drugs, without rendering the patient liable for the total cost of the prescription.

It is difficult to comprehend why one who is as sincere as Dr. Jaede, in his desire to improve the lot of the lower-paid worker, does not press with the greatest vigour for that complete freedom of prescribing which would be welcomed by all classes, with the possible exception of our Treasury officials.

Yours, etc.,

G. W. ASHBY.

80, Penshurst Street,
Penshurst,
April 11, 1945.

X-RAY SURVEY OF MINERS' CHESTS.

SIR: In the journal of the seventh instant, Dr. Gordon Smith comments on my letter on the above subject, which was published in the issue of March 24 *ultimo*.

Perhaps "lungs almost solid with coal dust" rather leans towards poetic licence, but I think most clinicians would infer that I meant the full black lungs of miners with from fifteen to twenty years on the coal face and not to those of the aged miner with advanced pulmonary fibrosis and even cavitation. The lungs I referred to show remarkably few changes radiologically and are quite comparable with those of the middle-aged worker on railway or road construction work, namely, an advancing linear fibrosis and not the nodular fibrosis of silicosis. I would suggest that Dr. Smith visit a large hospital such as Sydney Hospital and examine a few thousand films of middle-aged men; I am sure he would be staggered with the changes which occur in a worker's lungs without exposure to silica or coal dusts.

Dr. Smith's rather original suggestion that the term silicosis be restricted to workers in 90% silica dust shakes me. It would make it so difficult to deal with those tens of thousands who have been labelled as silicotics in Broken Hill, Cobar, Kalgoorlie and the rest of the world, to say nothing of numbers of coal miners who also show X-ray pictures typical of silicosis.

Coal dust is pretty innocuous, but coal mine dust contains free silica, and this after many years produces a nodular fibrosis in lungs which have been damaged by the blockage of the lymphatic system by coal dust particles; such cases are apparently commoner in Great Britain than in New South Wales.

I would like to warn Dr. Smith against being too enthusiastic about the silica content of lungs as shown by post-mortem laboratory tests. A lung with advanced silicosis may show very little silica, especially if the man has not worked in silica for years, while much silica may be found in the lungs of men who have been exposed recently to dust for comparatively short periods.

Yours, etc.,

J. G. EDWARDS.

Craignish,
185, Macquarie Street,
Sydney.
April 12, 1945.

RUBELLA AND DEAF-MUTISM.

SIR: I read with interest the article by Dr. N. McAlister Gregg entitled "Rubella during Pregnancy of the Mother, with its Sequelæ of Congenital Defects in the Child", which appeared in your journal on Saturday, March 31, 1945. To me the paper gives the impression that the association between rubella in pregnancy and congenital deaf-mutism was first observed in Sydney, and that the work of my colleagues and myself (THE MEDICAL JOURNAL OF AUSTRALIA, September 11, 1943, page 201, and May 6, 1944, page 409, *The Journal of Pathology and Bacteriology*, July, 1944, Volume LVI, Number 3, page 289, and *Transactions of the Ophthalmological Society of Australia* (*British Medical Association*), Volume IV, 1944, in the press) was merely confirmatory. With regard to deaf-mutism, I wish to state unequivocally that at no stage of our inquiry did any member of our team have the slightest inkling of the similar observations in New South Wales; the discovery in South Australia was made quite independently.

As mentioned in our first paper, Dr. A. L. Tostevin was the first to see a case of congenital deaf-mutism in association with maternal rubella in pregnancy; to him must go the credit for the discovery in this State. Another member of the committee helped by confirming the discovery and by assisting to determine more precisely the nature of the deaf-mutism.

Yours, etc.,

CHARLES SWAN.

Institute of Medical and Veterinary Science,
Adelaide,
April 10, 1945.

PROPOSED MEMORIAL TO THE LATE HAROLD OCTAVIUS LETHBRIDGE.

SIR: At a largely attended public meeting held in Narrandera, New South Wales, on November 20, 1944, it was unanimously decided to pay a tribute to the life of the late Dr. Harold Octavius Lethbridge by the establishment of some form of perpetual memorial. A committee was appointed to examine various proposals, to invite subscriptions, and later to report back to a further public meeting, whereat a decision would be made as to what form the memorial should take.

The greater part of the professional life of Harold Octavius Lethbridge was spent in Narrandera, and his outstanding ability was availed of throughout the greater portion of the Riverina during the whole of that time. His knowledge was readily available to all walks of life, and he was a true friend to all, but particularly to aborigines, "Diggers" and the poor. His sterling work in, and generosity to, the Narrandera District Hospital and his unflagging interest in the Intermediate High School leave both institutions deeply in his debt, and his pride of citizenship has left its mark throughout a wide area of both town and district. The full extent of his private generosity and many kindnesses will never be known. The museum at the local school, started by him for the preservation of aboriginal relics, was perhaps his keenest hobby. Owing to his sound knowledge of the Australian natives, this has grown to such an extent that it is not only interesting and educational, but, in many respects, unique and of great value to the public generally. The adequate housing of this museum has been freely mentioned as a form of memorial. This is mentioned as an indication that a considerable sum of money is hoped for, and subscriptions, large or small, will be welcome.

Subscriptions may be sent to any of the undersigned and will be duly acknowledged.

Yours, etc.,

H. B. ROWLANDS, President, Audley Street, Narrandera.
J. A. LORIMER, Honorary Secretary, P.O. Box 11, Narrandera.
H. G. GRACIE, Honorary Treasurer, P.O. Box 1, Narrandera.

Undated.

Post-Graduate Work.

NOTICE OF ALTERATION IN DATE OF LECTURE.

THE New South Wales Post-Graduate Committee in Medicine announces that the lecture on "Closed Head Injuries and Cerebral Contusion", to be given by Surgeon Captain Lambert Rogers, R.N.V.R., Consultant in Neurosurgery to the Royal Navy, will take place at the Stawell Hall, 145, Macquarie Street, Sydney, at 8.15 p.m., on Tuesday, May 1, 1945, instead of on the date originally announced. All civilian medical practitioners and service medical officers are invited to attend.

Nominations and Elections.

THE undermentioned have applied for election as members of the New South Wales Branch of the British Medical Association:

Allworth, Colin Travers, M.B., B.S., 1944 (Univ. Sydney), 147, Artarmon Road, Artarmon.

Chin, Ernest Favenc, M.B., 1940 (Univ. Sydney), 20, Hyde Brae Street, Strathfield.

The undermentioned have been elected as members of the New South Wales Branch of the British Medical Association:

Baird, John Speir, B.D.S., 1927, D.D.Sc., 1932, M.B., B.S., 1944 (Univ. Sydney), 175, Macquarie Street, Sydney.

Baker, Stephen Percy, M.B., B.S., 1944 (Univ. Sydney), 19, Shirley Road, Roseville.

Brenner, Maksymilian, M.B., B.S., 1942 (Univ. Queensland), 465, Oxford Street, Paddington.

Conacher, Colin James Ross, M.B., B.S., 1944 (Univ. Sydney), 131, Macquarie Street, Sydney.

Gayst, Henry, M.B., B.S., 1944 (Univ. Sydney), 12, Elva Avenue, Killara.

Graham, John Wedgwood, M.B., B.S., 1944 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.

Harris, Richard Lalor, M.B., B.S., 1940 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.

Henry, Margaret Tress, M.B., B.S., 1944 (Univ. Sydney), St. George District Hospital, Kogarah.

Johnson, Oscar Henry Louis, M.B., B.S., 1944 (Univ. Sydney), Base Hospital, Tamworth.

Kantor, Richard, M.D., 1910 (Univ. Vienna), also recommended and approved for registration in terms of Section 17 (2) of the *Medical Practitioners Act*, 1938, 135, Macquarie Street, Sydney.

Lane, Raymond Mervyn, M.B., B.S., 1942 (Univ. Sydney), NX176295, Captain R. M. Lane, 2/9 Australian General Hospital, Australian Imperial Force.

Manery, Mary, M.B., B.S., 1941 (Univ. Sydney), 159, Macquarie Street, Sydney.

Moloney, John, M.B., B.S., 1941 (Univ. Sydney), NX203642, Captain J. Moloney, 3 Aust. Ref. Trg. Bn. (J.W.), Canungra, Queensland.

Mutton, Broughton Vernon, M.B., B.S., 1943 (Univ. Sydney), 8, Warwick Street, Killara.

Stephenson, Arthur Lavender, M.B., B.S., 1941 (Univ. Sydney), 19, College Street, Drummoyne.

Walton, John William, M.B., B.S., 1943 (Univ. Sydney), 28, Jersey Street, Enfield.

Obituary.

EDWARD SUTHERLAND STOKES.

WE regret to announce the death of Dr. Edward Sutherland Stokes, which occurred on April 12, 1945, at Lindfield, New South Wales.

Australian Medical Board Proceedings.

TASMANIA.

THE undermentioned has been registered, pursuant to the provisions of the *Medical Act*, 1918, of Tasmania, as a duly qualified medical practitioner:

Nash (*née* Bradley), Gwendolyn Ruth, M.B., B.S., 1928 (Univ. Sydney), Hobart.

Medical Appointments.

Dr. Archibald McLean Harper has been appointed deputy quarantine officer at Port Kembla, New South Wales, under the provisions of the *Quarantine Act*, 1908-1924.

Diary for the Month.

APR. 24.—New South Wales Branch, B.M.A.: Ethics Committee.
APR. 25.—Victorian Branch, B.M.A.: Council Meeting.
APR. 26.—New South Wales Branch, B.M.A.: Branch Meeting.
APR. 26.—South Australian Branch, B.M.A.: Scientific Meeting.
APR. 27.—Queensland Branch, B.M.A.: Council Meeting.
MAY 1.—New South Wales Branch, B.M.A.: Organization and Science Committee.
MAY 2.—Victorian Branch, B.M.A.: Branch Meeting.
MAY 2.—Western Australian Branch, B.M.A.: Council Meeting.
MAY 3.—South Australian Branch, B.M.A.: Council Meeting.
MAY 4.—Queensland Branch, B.M.A.: Branch Meeting.
MAY 8.—New South Wales Branch, B.M.A.: Executive and Finance Committee.
MAY 8.—Tasmanian Branch, B.M.A.: Ordinary Meeting.
MAY 11.—Queensland Branch, B.M.A.: Council Meeting.
MAY 14.—Victorian Branch, B.M.A.: Hospital Subcommittee.
MAY 14.—Victorian Branch, B.M.A.: Finance, House and Library Subcommittee.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Natives' Association; Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phœnix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178, North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205, Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia. All Public Health Department appointments.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

All communications should be addressed to the Editor, THE MEDICAL JOURNAL OF AUSTRALIA, The Printing House, Seamer Street, Glebe, New South Wales. (Telephones: MW 2651-2.)

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